Health Care Financing Administration Rulings

On Medicare, Medicaid, Professional Standards Review and Related Matters

HCFAR 79–1 to HCFAR 79–27

HCFA
Baltimore, Md. 21235
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Foreword

Programs of the Health Care Financing Administration—including Medicare, Medicaid, and Professional Standards Review Organizations—affect millions of people throughout the United States. To fully understand these programs, it is necessary to have access to the administrative instructions and manuals which guide staffs of Federal and State agencies and HCFA contractors in implementing the programs. In addition, official public rulings of the agency show how regulations are interpreted and applied.

Thus, in publishing *HCFA Rulings* quarterly, HCFA's intent is to observe the spirit of the Freedom of Information Act: to keep the public informed about the agency's handling of the public's business. As required by law, this document contains listings and indexes of current program regulations, manuals, instructions, rulings, and decisions. In addition, it includes illustrative case decisions, which serve as binding precedents upon those who administer the HCFA programs and upon those who serve as hearing officials in various program appeals. These decisions are being compiled in a timely fashion in order to promote consistency in interpretation of policy and adjudication of disputes.

HCFA Rulings should be of use to Medicare and Medicaid beneficiaries, Federal and State employees who administer these programs, intermediaries, carriers, providers of services under the programs, other contractors to HCFA, attorneys, court and hearing personnel, and interested members of the public.

HCFA Rulings is a successor to *SSA Rulings*, in which Medicare cases and indexes appeared prior to the HEW reorganization of 1977. At that time, the Medicare program was transferred to this agency from the Social Security Administration.

The first two issues of *HCFA Rulings* have contained predominantly Medicare case materials. Future issues will also carry cases concerning Medicaid and Professional Standards Review Organizations.

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Health Care Financing Administration

Subscription Information

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42 CFR 405.312(c) HCFAR–79–1

Held, section 405.312(*c*) of Health Care Financing Administration Regulations No. 5 (42 CFR 405.312(c)), which authorizes payment under title XVIII of the Act for items or services furnished an individual in or by a participating State or local government hospital which serves the general community, is not applicable to items or services furnished a prisoner, since such prisoners are public charges who cannot incur expenses which are reimbursable under title XVIII of the Act.

Section 1862(a)(3) of the Social Security Act provides, in part, that no payment may be made under title XVIII of the Act for any expenses incurred for items or services "which are paid for directly or indirectly by a governmental entity * * * except in such cases as the Secretary may specify." Pursuant to authority derived from this section, the Secretary of Health, Education, and Welfare has authorized by regulation an exception permitting participating State or local governmental hospitals which serve the general community to receive payment for covered services furnished to individuals, regardless of the restrictions in section 1862(a)(3).

Section 405.312 of Health Care Financing Administration Regulations 42 CFR 405.312) provides, in part, as follows:

> Payment may not be made under title XVIII of the Act for expenses incurred for items or services that are paid for directly or indirectly by a government entity, except:
> * * * * * * *
> (c) Payment may be made for items and services furnished an individual in or by a participating hospital operated by a State or local government entity, where such hospital is a general or special hospital serving the general community, including a mental or tuberculosis hospital or a hospital for treatment of infectious disease.

A question has arisen whether the foregoing provisions of the regulations authorizes payment under title XVIII of the Act for otherwise covered items and services which are provided a prisoner in a participating hospital which serves the general community and is operated by a State or local governmental entity.

One objective of the exception specified by the Secretary in section 405.312(*c*) of the regulations was to make medical services available to the elderly indigent without requiring them to submit to a test of their ability to pay. In addition, a number of States provide free medical treatment to victims of tuberculosis and other communicable diseases, regardless of their ability to pay, so as to encourage all persons with these conditions to seek treatment with the knowledge that they will not have to

pay for this treatment. In this way, the State protects all its residents against the danger of the spread of communicable diseases. It is felt that these programs further the objectives of title XVIII and that permitting payment for aged persons treated by the States under these programs is a desirable exercise of the Secretary's discretion. The exception thus appears to recognize the title XVIII program responsibility to encourage public health programs.

However, the intention of section 405.312(*c*) of the regulations was not to create an exception relieving the States of their obligation to maintain prisoners; the specification of such an exception would not be within the authority granted the Secretary because section 1862(a)(2) controls situations where individuals (e.g., prisoners) have no legal obligation to pay for the items and services furnished to them. The authorities responsible for the custody of the prisoners are obligated to provide for their needs as a cost attendant upon their confinement in custody. However, a prisoner is not a recipient of a public bounty; he is a public charge. He has no right to elect the method of procuring care, whereas the authorities who hold him must provide this care because he is deprived of choice of action. Since he cannot obtain his own medical care and treatment and is not chargeable with the expense of such care and treatment, he cannot incur expenses for which reimbursement could be made under title XVIII of the Act.

Accordingly, it is *held* that section 405.312(*c*) of the Health Care Financing Administration Regulation which authorizes payment under title XVIII of the Act for items or services furnished an individual by a participating State or local governmental hospital which serves the general community, is not applicable to items or services furnished prisoners.

(X–refer to SSR–68–26)

SECTION 1862(a)(2).—CHARGES FOR HOSPITAL SERVICES LIMITED TO AMOUNT OF HEALTH INSURANCE COVERAGE

42 CFR 405.311 HCFAR–79–2

> Where a participating hospital has a policy of limiting its charges to the extent of the patient's coverage under commercial health insurance or health insurance under title XVIII of the Social Security Act and waiving collection of all its charges in the case of indigent patients who have no such insurance coverage, *held*, section 1862(a)(2) of the Social Security Act does not bar payment on behalf of a beneficiary for covered services furnished by such hospital, since such services are not services for which the beneficiary has no legal obligation to pay and which no other person has a legal obligation to pay for or provide.

The X Hospital, a private non-profit institution, is a participating hospital in the Health Insurance for the Aged Program under title XVIII of the Social Security Act. It is the policy of the hospital to waive collection of its charges to indigent patients who have no health insurance coverage of any kind. However, in the case of patients who have health insurance,

the hospital limits its charge to the extent of the patient's coverage under commercial health insurance and to the extent of his coverage under title XVIII of the Act. Upon admission to the hospital the patient signs an admission form under which, in substance, the patient agrees to pay and to be liable for all bills and charges, and by which the hospital agrees voluntarily to limit these bills and charges to the extent of his health insurance coverage.*

Section 1862(a) of the Social Security Act provides in pertinent part that:

> Notwithstanding any other provision of this title, no payment may be made under Part A or Part B [of title XVIII of the Act] for any expenses incurred for items or services—* * *.
>
> (2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for; * * *.

In the light of the hospital policy, a question has been raised as to whether section 1862(a)(2) (supra) precludes payment on behalf of a beneficiary whose liability to the hospital does not extend beyond his coverage under title XVIII. The answer to this depends upon whether the services provided under the circumstances described herein are services for which the individual has no legal obligation to pay and which no other person has a legal obligation to provide or pay for.

Under the terms for admittance to X Hospital, a patient specifically assumes liability for all charges, but the hospital in turn commits itself to limit its charges to the extent of the patient's health insurance coverage. It would appear, therefore, that the hospital does charge for its services, but conditions collections within limits governed by the patient's commercial health insurance coverage and health insurance coverage under title XVIII of the Social Security Act. The fact that the hospital waives collection of its charges in the case of indigent patients not having hospital, medical, or surgical insurance coverage does not mean that the hospital customarily does not charge for its services or that the hospital intends to waive collection of its charges in the case of individuals who have insurance coverage under title XVIII of the Social Security Act.

Thus, it is apparent, the X hospital does not provide services gratuitously for insured individuals, and, therefore, it cannot be said that the services provided are services for which "the individual * * * has no legal obligation to pay, and which no other person * * * has a legal obligation to provide or pay for; * * *." *Held,* section 1862(a)(2) of the Social Security Act does not bar payment on behalf of a beneficiary under

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* The hospital may not collect *both* from the title XVIII "medicare" program and from the patient's commercial insurance policy for services covered under title XVIII. Where the patient has commercial insurance and is also a medicare beneficiary, a participating hospital must bill the title XVIII program for its costs for covered items and services (as reduced by deductible and coinsurance amounts, if any). It can look to the patient (or commercial insurance) only for the deductible and coinsurance and for items and services not covered under title XVIII. (Commercial policies available to persons 65 or older frequently provide payment for the inpatient hospital deductible and for inpatient coinsurance amounts.)

title XVIII of the Social Security Act for covered services provided at the X Hospital.

(X–refer to SSR 68–40)

SECTION 226.—HOSPITAL INSURANCE BENEFITS—5 YEARS CONTINUOUS UNITED STATES RESIDENCE

HCAF–79–3a*

Periods of temporary absence from the United States after an alien has been lawfully admitted for permanent residence in the United States may be included in the period of 5 years continuous residence immediately preceding the month in which he files application for hospital insurance benefits under section 103(a) of P.L. 89–97 (Social Security Amendments of 1965) but only if the evidence shows he intended to retain a United States residence throughout the period beginning with his departure and ending with his later return to the United States.

Claimant, an alien, who became 65 years of age before 1968 and was neither entitled to monthly benefits under section 202 of the Social Security Act nor railroad retirement benefits, filed an application for hospital insurance benefits under section 103(a) of P.L. 89–97 on December 23, 1965. The evidence established that claimant was lawfully admitted to the United States for permanent residence on October 27, 1955; that she left for a visit to Australia in October 1961 after having obtained from the Immigration and Naturalization Service a re-entry permit valid for 1 year, which permit was later extended for 1 additional year to October 22, 1963; that she returned to the United States on October 12, 1964, having been granted a returning resident visa by a United States Consul in Australia; and that when she departed for Australia she left most of her personal property in the United States and throughout her absence she maintained a savings account jointly with her daughter in the United States. *Held*, evidence establishes claimant intended to retain her United States residence throughout her absence and thus that her absence was only temporary, so that she may be considered to have resided in the United States continuously for 5 years immediately preceding the date of her application within the meaning of section 103(a) of P.L. 89–97. Further *held*, since all other requirements of section 103(a) were met, claimant is deemed, for purposes of section 226 of the Social Security Act, to be entitled to monthly benefits under section 202 of the Act and thus she is entitled to hospital insurance benefits under section 226 of the Act.

This case is before the Hearing Examiner pursuant to an Order of the Appeals Council of the Bureau of Hearings and Appeals—Social Security Administration (SSA) dated April 28, 1967, remanding the case for the purpose of holding a hearing and rendering a recommended decision in connection with claimant's entitlement to Hospital Insurance benefits under the Social Security Act. The claimant was not present, but her daughter as her duly appointed representative was present and participated in such hearing.

* Rulings based upon cases decided by the Appeals Council of the Bureau of Hearings and Appeals, Social Security Administration, which represent the final decision of the Secretary, HEW, are identified throughout the publication by a suffix "a" after the ruling number.

The claimant, on December 23, 1965, filed an application for Hospital Insurance entitlement, alleging that she was born in Hungary, not a citizen of the United States but that she had been a resident of the United States since October 1955. The claimant was informed by the Bureau of Retirement and Survivors Insurance (SSA) that her application had been denied because she had not resided in the United States continuously for the five year period immediately preceding the month in which she filed her application. The claimant requested reconsideration of that determination and was informed that after reconsideration the initial disallowance was correct and in accordance with the law and regulatons.

The general issue before the Hearing Examiner is whether the claimant based upon her application filed on December 23, 1965, is entitled to Hospital Insurance benefits under the provisions of the Social Security Act, as amended. This is dependent upon whether or not the claimant has resided in the United States continuously during the five years immedately preceding the month in which she filed her application.

Section 226 of the Social Security Act, as added by Section 101 of Public Law 89–97 (the Social Security Amendments of 1965), provides, as pertinent here, that:

> (a) Every individual who–(1) has attained the age of 65, and (2) is entitled to monthly insurance benefits under section 202 or is a qualified railroad retirement beneficiary, shall be entitled to hospital insurance benefits * * * for each month for which he meets the conditions specified in paragraph (2), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2).

Although the claimant had attained age 65 at the time of filing her application she was not entitled to monthly insurance benefits and was not a qualified railroad retirement beneficiary and therefore, does not meet the requirements of section 226(a) of the Act. However, under section 103(a) of P.L. 89–97, a person who is not entitled to a monthly insurance benefit under section 202 may nevertheless become entitled to hospital insurance benefits if certain requirements are met.

Section 103(a) provides as pertinent here:

> (a) Anyone who—
> (1) has attained the age of 65,
> (2) (A) attained such age before 1968 * * *,
> (3) is not, and upon filing application for monthly insurance benefits under section 202 of the Social Security Act would not be entitled to hospital insurance benefits under section 226 of such Act *xxxx* * * *.
> (4) is a resident of the United States (as defined in section 210(i) of the Social Security Act), and is (A) a citizen of the United States or (B) an alien lawfully admitted for permanent residence who has resided in the United States (as so defined) continuously during the 5 years immediately preceding the month in which he files application under this section, and
> (5) has filed an application under this section in such manner and in accordance with such other requirements as may be prescribed in regulations of the Secretary, shall * * * be deemed, solely for purposes of section 226 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning with the first month in which he meets the requirements of this subsection * * *

The claimant was lawfully admitted to the United States as a permanent resident on October 27, 1955. In October 1961 she went to Australia where she remained until sometime in October 1964 when she returned and resumed living with a daughter in New York. As the claimant is not a citizen of the United States, the Bureau of Retirement and Survivors Insurance (SSA) disallowed her application because she began her last period of permanent residence in the United States in October 1964, and consequently, had not resided continuously for 5 years in the United States immediately prior to filing her application. In its determination the Bureau pointed out that when claimant filed her application, she stated that in 1961 she went to live with her sons in Australia and submitted very little evidence to indicate an intention to maintain a residence in the United States during the 3 years of absence between 1961 and 1964. Further, photocopy of a bank account shows first deposit was in July of 1964 and the entire account was withdrawn in July of 1966, and which account was in the name of her daughter in trust for the claimant, also; a so-called "visit" out of the country for an extended period (over 6 months) cannot be generally considered a temporary visit in the absence of strong evidence of an intent to maintain a residence in this country.

Under the guides as set down by Social Security Ruling 67–20, C. B. 1967, p. 95, in considering a period of residence, a person is a resident of the United States if he is making his home in the United States. Actual physical presence is an important factor in establishing a residence. However, an individual may still be a resident even though he is temporarily absent from the United States, intending to return to a home in this country and does later return, the temporary absence does not interrupt the period of residence in the United States. However, if the visit is for any extended period e.g., more than 6 months, it could not generally be considered a temporary visit in the absence of a strong showing to the contrary, such as maintaining a house or apartment in this country, *paying United States Income Taxes for* the period of his absence, *departing with a re-entry permit* (emphasis underlining supplied) or performing other similar acts showing his intention to retain a residence in the United States.

Claimant's daughter testified that her mother, the claimant, came here as a permanent resident in 1955; that claimant lived with her, opened an account in the [X] Savings and Loan Association and which account was in their joint names because claimant could not read or write English; that her mother left for Australia the latter part of October 1961, to visit her two sons and to attend the contemplated marriage of one of the grandchildren. During her stay in Australia she stayed with one of the sons. The daughter insisted that prior to her mother's leaving, she had written to the Immigration Department to extend her mother's right to come back as she explained that any alien could leave the country and return without a re-entry permit but if they left the country for over a year and intended to return, a re-entry permit was required. She submitted a letter from the Immigraton service to corroborate that the re-entry permit was granted and had been forwarded to the American consulate in Australia on October 23, 1961. When her mother left for Australia she only took clothes with her to stay for a few months and left most of her clothing and personal

belongings in her room. There was also submitted evidence of an account in the [Y] Savings Bank opened on July 6, 1966, which she stated was the same money which was in the [Z] Savings Bank opened on July 6, 1964, obtained from the first account in [X Savings and Loan Association] in existence from September 28, 1959 to July 2, 1964. Claimant has lived with her for the past several months. Upon her return from Australia she lived with her grandchild for convenience sake but as her daughter now has a 5½ room apartment there is room for her.

Information now before the Hearing Examiner and not before the Bureau of Retirement and Survivors Insurance (SSA) discloses that the applicant and her daughter were the joint owners of a savings account in the [X] Savings and Loan Association, opened on September 28, 1959 and cancelled on July 2, 1964; that the daughter opened up an account in trust for the claimant on July 6, 1964, in the [Z] Savings Bank after the daughter gave up her farm; that in July 1966 the account was transferred to the [Y] Savings Bank, closer to where the claimant and her daughter now reside.

Information obtained from the Immigration and Naturalization Service indicates claimant was admitted to the United States as a permanent resident on October 27, 1955, and she left for Australia in October 1961 at which time she was issued a re-entry permit which was valid for 1 year. [This] re-entry permit was extended during her absence from this country and upon her arrival here on October 12, 1964, was in the possession of a returning resident visa issued by [an] American Consul [in] Australia, establishing the claimant's intention to retain a residence in the United States throughout the 3 year period she was visiting in Australia.

After careful consideration of the entire record, the Hearing Examiner makes the following findings:

1. The claimant attained the age of 65 before 1968, is not a citizen of the United States, but was lawfully admitted here as a permanent resident on October 27, 1955. She left the United States for a visit to Australia on or about October 27, 1961, at which time she was issued a re-entry permit which was valid for one year, that such re-entry permit was extended for one additional year to October 22, 1963 and when she returned to the United States on October 12, 1964, she had in her possession a returning resident visa issued by [an] American Consul [in] Australia. In addition, during her absence the claimant was the owner of a joint savings account in this country, together with her daughter, all of which show her intention to retain her residence in the United States. The 3 year period claimant was in Australia, from October 1961 to October 1964 is found to be a temporary visit.

2. The claimant has resided in the United States continuously from October 27, 1955 to the present time, a period in excess of 5 years immediately preceding December 23, 1965, when she filed her application for Hospital Insurance benefits.

3. The claimant for the purpose of entitlement to Hospital Insurance benefits under Section 226 of the Social Security Act, is deemed entitled to monthly insurance benefits under section 202 of the Social Security Act in accordance with Section 103(a) of Public Law 89–97.

RECOMMENDED DECISION

It is the recommended decision of the Hearing Examiner that the claimant based upon her application filed on December 23, 1965, is entitled to Hospital Insurance benefits under the provisions of section 226 of the Social Security Act, as added by section 101 and pursuant to section 103(a) of Public Law 89–97 (of the Social Security Amendments of 1965.) [*]

(X–refer to SSR–68–65a)

SECTION 1803, 1862(a)(3) and 1862(b).—COVERED HOSPITAL SERVICES—SIMULTANEOUS REIMBURSEMENT UNDER TITLE XVIII OF SOCIAL SECURITY ACT AND AS PART OF AWARD UNDER FEDERAL TORT CLAIMS ACT

HCFAR–79–4

Where an award under the Federal Tort Claims Act for damages suffered by a Part A beneficiary included amounts to reimburse him for hospital and medical expenses also covered under title XVIII of the Social Security Act, *held,* (1) payments under the Federal Tort Claims Act do not constitute payments by a "governmental entity" for purposes of the exclusion in section 1862(a)(3) of the Social Security Act; (2) the Health Care Financing Administration is given no right to recover such amounts (i.e., the right of subrogation) or any other form of reimbursement from third-party tortfeasors by title XVIII of the Act; and (3) the beneficiary is permitted reimbursement under both title XVIII and the Federal Tort Claims Act, since there is nothing inconsistent with simultaneous reimbursement under the program and from other sources (with the sole exception of the priority of workmen's compensation payments), since title XVIII is in the nature of social insurance.

A beneficiary entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act was admitted to a hospital for the treatment of injuries received as the result of the negligence of a driver of a U.S. mail truck. The hospital and medical services were found covered under Part A, and reimbursement therefor was made to the provider-hospital pursuant to the provisions of title XVIII of the Social Security Act. Thereafter, an award for damages suffered by the beneficiary was approved by the Post Office Department under the terms of the Federal Tort Claims Act. This award included an amount to reimburse the beneficiary for hospital and medical expenses. However, the Post Office Department is withholding a portion of the award from the beneficiary, equal to the amount paid the hospital under title XVIII, pending advice as to its disposition.

Two questions are raised by the instant case: (1) whether the health care payments awarded under the Federal Tort Claims Act represent payment by

[*] After careful consideration of the entire record, on November 14, 1967, the Appeals Council adopted the hearing examiner's recommended decision and made it the decision of the Appeals Council. [ED.]

a government entity and are therefore excluded from coverage under section 1862(a)(3) of the Social Security Act; and (2) whether title XVIII of the Social Security Act gives the health insurance program the right to recover from the third-party tortfeasor (Post Office Department) that portion of the tort claim award intended to reimburse the beneficiary for hospital and medical expenses incurred.

Where payment has been made to an individual under the Federal Tort Claims Act for expenses incurred for medical and hospital services which are also covered under title XVIII of the Social Security Act, such services are not considered to have been "paid for directly or indirectly by a governmental entity" for purposes of the exclusion in section 1862(a)(3) of the Social Security Act. Rather, such payments constitute payment of damages by a third-party tortfeasor for which reimbursement may also be made under title XVIII.

The right of the United States to recover from third-party tortfeasors financial expenditures made by it pursuant to legal requirement in connection with the medical care of an injured individual must devolve from an act of Congress. (*United States* v. *Standard Oil*, 67 S. Ct. 1604 (1947)). As a consequence of the opinion of the Supreme Court in the *Standard Oil* case, there was enacted the Federal Medical Care Recovery Act, 42 U.S.C. 2651 *et. seq.*, which establishes a right in the United States to seek recovery from third-person tortfeasors for the reasonable value of medical services furnished directly by the Federal Government to an individual who suffered injury as a result of the action of such third persons. However, there are no provisions in title XVIII of the Social Security Act establishing subrogation rights in the Secretary of Health, Education, and Welfare or otherwise authorizing him to accept reimbursement out of awards under the Federal Tort Claims Act for health insurance payments he made for services covered under Medicare.

In this regard, it may also be noted that only in respect to workmen's compensation does title XVIII of the Social Security Act recognize a priority of other insurance coverage by providing in section 1862(b) that:

> Payment * * * may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made * * * with respect to such item or service, under a workmen's compensation law or plan of the United States or a State. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when * * * payment for such item or service has been made under such a law or plan.

Furthermore, the nature of title XVIII reimbursement as social insurance—in contrast to those "government payments" specified by the Federal Medical Care Recovery Act—is emphasized by the provision of section 1803 of the Social Security Act that:

> Nothing contained in this title shall be construed to preclude any State from providing or any individual from purchasing or otherwise securing, protection against the cost of any health services.

Thus, it is specifically recognized that there is nothing inconsistent with simultaneous reimbursement to the beneficiary from sources other than title XVIII—with the sole exception of the above-quoted provision excluding title XVIII payment in the event of workmen's compensation coverage.

Accordingly, it is *held* that payments under the Federal Tort Claims Act do not constitute payments by a "governmental entity" for purposes of the exclusion in section 1862(a)(3) of the Social Security Act; title XVIII of the Social Security Act provides no right of subrogation or any other form of reimbursement from third-party tortfeasors; and, with the sole exception of the priority of workmen's compensation payments, there is nothing inconsistent with simultaneous reimbursement under the Medicare program and from other sources since title XVIII is in the nature of social insurance.

(X–refer to SSR 69–8)

SECTIONS 1861(b)(1) and 1861(v)(2)(A). PAYMENT TO PROVIDER-HOSPITAL FOR PRIVATE ACCOMMODATIONS FURNISHED IN EMERGENCY DEEMED "REQUIRED FOR MEDICAL REASONS"

HCFAR–79–5

Where a Part A beneficiary requiring immediate hospitalization, but not isolation, is assigned a private room by the provider-hospital because no semi-private or ward accommodations are then available, *held* (1) the furnishing of a private room under such circumstances may be considered as being "required for medical reasons"; (2) payment may be made to the hospital for such accommodations under section 1861(v)(2)(A) of the Social Security Act; and (3) the beneficiary is not subject to additional charge by the hospital therefor.

A person entitled to hospital insurance benefits under Part A of title XVIII of the Act was admitted to a hospital under emergency circumstances when no semi-private or ward accommodations were available for his use, and was assigned to a private room. The beneficiary was advised that there would be a specified daily charge for the private accommodations which he himself would have to pay the hospital, and, on his discharge 14 days later, he was billed accordingly.

As provided in pertinent part by section 1812 of the Social Securty Act, a beneficiary under Part A is entitled to have payment made on his behalf for inpatient hospital services for up to 90 days during any benefit period, plus a 60-day "lifetime reserve." Pursuant to section 1861(b)(1) of the Act, the term "inpatient hospital services" includes the bed and board furnished the inpatient of a hospital. The measure of program responsibility for the cost of bed and board is set forth in section 1861 (v)(2)(A) of the Act as follows:

(2)(A) If the bed and board furnished as part of inpatient hospital service (including inpatient tuberculosis hospital services and inpatient psychiat-

ric hospital services) or posthospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

The questions at issuse are (1) whether or not the program may pay the hospital the cost of such private accommodations furnished the beneficiary, pursuant to the provisions of section 1861(v)(2)(A) of the Act cited above; and (2) whether or not the provider-hospital may charge the beneficiary for the private accommodations (where such charge does not exceed the difference between the hospital's usual charge for semi-private accommodations and its usual charge for the private room.)

Paragraph (2)(A) of section 1861(v), read in conjunction with paragraph (3) of that section (which provides for a reduction in cost reimbursement for the unauthorized assignment of a patient to less than four-bed accommodations) establishes the type of room accommodations which it is contemplated will be furnished ordinarily to program beneficiaries, i.e., two-to four-bed accommodations. With respect to private room accommodations, therefore, unless the patient requires them for medical reasons, the program will pay for them only at the semi-private room cost rate. Conversely, as provided in section 1866(a)(2)(B), where the more expensive accommodations are furnished at the request of the beneficiary, and are not required for medical reasons, he may be billed for the specified amount, provided such amount does not exceed the difference between the hospital's usual charge for semi-private accommodations and its usual charge for the accommodations furnished him at his request.

The Act itself does not explain what medical reasons would require the assignment of a patient to accommodations more expensive than semi-private accommodations, but some indication of the Congressional intent is found in the committee reports. Thus, in the report of the Committee on Ways and Means (House Report No. 213, 89th Cong., 1st sess.) the above-cited pertinent sections of the Act are synthesized and explained in the following manner:

> Hospital room and board would be paid in full in accommodations containing from two to four beds. Payment would also be made for private accommodations where their use is medically indicated—ordinarily only when the patient's condition requires him to be isolated. Where private accommodations are furnished for the patient's comfort, the payments would cover only the equivalent of the reasonable cost of accommodations containing two to four beds; the patient would pay the extra charges for the private room.

(See also the report of the Senate Committee on Finance (Rept. 404, Part I, 89th Cong., 1st sess., at page 27),)

That the single illustration of a medical situation which requires private room assignment was not intended to be exclusive is suggested by the word "ordinarily" which introduces the illustrative clause. Nevertheless, the example employed carries the strong implication that the health care needs of the patient, or the need to keep the patient apart from other patients, would dictate the coverage of private room accommodations in most instances.

However, where immediate inpatient hospitalization is required because of the emergency nature of the medical condition of the patient and where no semi-private or less than semi-private accommodations are available at the time of admission, medical reasons for the use of a private room can be said to exist. On these facts, clearly the private accommodations are furnished not for the personal comfort of the patient but because he needs inpatient care at the time of admission. Although his conditon may not require private accommodations, the necessity for inpatient service would seem to justify furnishing of that service in the only accommodations then available, so that the service so furnished under such circumstances could reasonably be considered to be a covered service.

The effect of such a holding is twofold: (1) The program is obligated to pay the provider the full cost of the private accommodations; and, (2) the provider would not be authorized to bill the patient any additional amount not attributable to deductibles or coinsurance. This latter condition is the more important consequence of the interpretation, especially where there is no significant difference in the bed and board cost between private rooms and semi-private rooms. To the extent that hospitals have been assessing charges for the use of private accommodations, this position would tend to withdraw what may have been an additional source of income to such hospitals. Nevertheless, a patient in urgent need of immediate hosptalization can hardly be considered to have elected private room assignmnt for his personal comfort when the only reason for the assignment is the nonavailability of other accommodations. Where payment is made under title XVIII for the full cost of any item or service furnished to a beneficiary, the beneficiary may not be charged by the provider for such item or service.

Of course, the subsequent availability of semi-private or ward accommodations would offer to the hospital the right to transfer the patient to such accommodations or, at the express request of the patient, allow him to continue occupancy of the private room as a private room, and not an emergency, patient enjoying a personal comfort item subject to an appropriate charge. The hospital, moreover, may also assign a patient admitted for emergency treatment to less than semi-private room accommodations as an alternative to private room assignment without suffering the penalty provided in section 1861(v)(3) of the Act. The assignment of a patient for emergency treatment to accommodations less expensive than semi-private accommodations because semi-private accommodations were not available would be for a reason consistent with the purposes of the Act, but transfer to semi-private accommodations would be required when available.

Accordingly, it is *held* that the furnishing of a private room to a beneficiary under the circumstances in this case may be considered as being "required for medical reasons" within the purview of section 1861(v)(2)(A) of the Social Security Act; that the hospital-provider may be reimbursed for the full cost of such private accommodations; and that it is not authorized to bill the beneficiary therefor.

(X–refer to SSR 69–42)

SECTION 1862(b).—HEALTH INSURANCE BENEFITS—WORKMEN'S COMPENSATION EXCLUSION FROM COVERAGE—LUMP-SUM COMPROMISE AWARD

42 CFR 405.316 and 405.320 HCFAR–79–6

> Where a compromise settlement in a disputed workmen's compensation claim has been reached and, in accordance with the State statutory requirement, has been approved by the workmen's compensation board or commission, *held,* to the extent the settlement could reasonably be deemed reimbursement of medical expenses, payment may not be made under title XVIII of the Social Security Act, by virtue of section 1862(b) thereof.

D, who was entitled to hospital insurance benefits under title XVIII of the Social Security Act, entered into a compromise and release agreement with his employer's workmen's compensation carrier, to settle all claims arising from injuries resulting from a heart attack and fall while at work. The total amount of D's claim including compensation for disablity and medical expenses was $40,000. The compromise was entered into because there was a question as to whether D's injuries arose in the course of his employment. Pursuant to California State law, this agreement was submitted to the Workmen's Compensation Board for approval and was found to be fair and adequate, in view of the fact that a bona fide dispute existed as to whether the injury occurred in the course of D's employment. Settlement consisted of a lump-sum payment of $8,000 and it was agreed that unpaid and future medical and hospital expense, if any, was to be the sole responsibility of the applicant. A claim for payment of medical and hospital expenses incurred by D in the treatment of his injuries was filed.

The benefits provided an individual by the health insurance program under title XVIII of the Act consist of entitlement to have payment made on his behalf for health and medical services, subject to certain exclusions and limitations contained in the Act. One such exclusion, contained in section 1862(b) of the Act, provides that:

> Payment under this title may not be made with respect to any item or service *to the extent that payment has been made,* or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, *under a workmen's compensation law* or plan of the United States or a State. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan. (Emphasis supplied.)

The question raised by the instant case is whether, and to what extent, the compromise agreement made by D represents a payment (or potential payment) with respect to medical services, under a workmen's compensation law or plan of the United States or a State, so as to limit payment under section 1862(b).

Congress, recognizing a potential dual coverage because of the avail-

ability in certain situations of both title XVIII health insurance benefits and workmen's compensation benefits to pay for medical expenses, included section 1862(b) supra, to avoid payment of medical expenses for which the States had already made provision under the workmen's compensation laws, regardless of whether compensation was sought by the beneficiary. It was felt that to permit health insurance payments in those instances, would constitute an encroachment upon established State programs. (See Senate Report No. 404, 89th Congress, 1st Session, p. 49; and House Report No. 213, 89th Congress, 1st Session, p. 42.)

The Act unmistakably provides that the priority of workmen's compensation benefits exists only to the extent that there is or could be deemed to be payment for medical expenses under the State program. The law, moreover, does not require that the total amount of a lump-sum compensation award must be treated in all cases as an award for medical expenses alone. Such an interpretation ignores the element of earnings replacement, which is a feature of workmen's compensation equal in importance under compensation law to indemnification for medical expenses incurred by the workman as a consequence of a work-related injury or illness.

An approved compromise award is generally held to constitute "compensation" within the meaning of most workmen's compensation laws and to have the same force and effect as a compensation award. However, recognition must also be granted to the essential and distinctive nature of such an award, realizing that under State law this award does not per se justify a conclusion that the claimant could have obtained all benefits payable under the workman's compensation law if he had pursued his remedies further. Where some basis for doubt actually exists as to the industrial connection of the injury, the most that can reasonably be expected is approval by the compensation commission, or like body, of a compromise which settles the claim conclusively in the amount approved (although not the apportionment of the amount).

While a compromise award is incorporated into the workmen's compensation system through a requirement of approval by the Industrial Accident Commission to insure fairness to the claimant, it grants by its very basis in the contested liability, less than full benefits in terms of both medical expenses and income replacement. By its provisions, however, an agreement will, as in the instant case, give recognition to the existence of the medical expenses incurred by the claimant, and grant release of the claim because of the payment. Therefore, in applying the directives of section 1862(b) of the Social Security Act to a compromise award, it must be determined not only how much of the lump-sum award is attributable to medical expenses but also what percentage of those medical expenses were actually intended to be reimbursed.

Under this approach, the Health Care Financing Administration through its intermediaries, will separate that part of a lump-sum award which reimburses the claimant for medical expenses from that part which is intended as replacement of lost income, where such separation is possible. Where it is a lump-sum compromise award, as in the instant case, the award must be examined further to determine the proportion of the

medical expenses which has in fact been covered by the award.*

To determine what part of the compromise award in the instant case was intended to cover medical expenses, we can make use of the following formula, similar to the one used by the court in *California-Western States Life Insurance Co.* v. *Industrial Accident Commission,* (cited in ftn.*) for calculating the amount of lien to be allowed for unemployment disability benefits: First, the amount of the total workmen's compensation claim, had the claimant fully pursued his remedies successfully, is estimated. Second, the ratio of the amount awarded as a compromise to the foregoing estimate is calculated. Then the same ratio is applied to the total medical expenses incurred by the beneficiary-claimant, to arrive at the amount to be considered reimbursement for medical expenses by the compromise award. The difference between this last figure—the amount estimated as medical expenses covered by the compromise award—and the total medical expenses incurred, would be reimbursable as expenses for which payment has not been nor can reasonably be expected to be made under a workmen's compensation law, within the meaning of section 1862(b) of the Act. Thus, in the case of D, the amount awarded as a compromise ($8,000) is 20 percent of the amount of the total claim ($40,000), had D pursued his remedies successfully. Accordingly, 20 percent of the total medical expenses incurred would be considered reimbursed by the compromise award. The remaining 80 percent would be considered not covered by the compromise award, and thus reimbursable under title XVIII.

Application of such a formula reflects the prevailing treatment of lump-sum compromise awards in most jurisdictions. Moreover, it is in accord with the congressional intent to avoid payment under title XVIII of expenses for which the States had already made provision under their workmen's compensation laws. Accordingly, it is *held* that the Health Care Financing Administration through its intermediary, may properly examine the compromise agreement made by D with the approval of the State's workmen's compensation commission, to determine whether and to what extent, it represents payment made, or which can reasonably be expected to be made, for medical services under a workmen's compensation law, so as to preclude payment under section 1862(b) of the Social Security Act for some or all of such services.

(X–refer to SSR 70–38)

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* See in this regard: *Aetna Life Insurance Co.* v. *Industrial Accident Commission,* 38 C. 2d 599, 241 P.2d 530 (1952); West's Ann. California Labor Code, § 4903(f); *Garcia* v. *Industrial Accident Commission,* 41 Cal. 2d 257, 263 P.2d 8 (1953); *California-Western States Life Insurance Co.* v. *Industrial Accident Commission,* 59 Cal. 2d 257, 379 P.2d 328 (1963).

SECTION 1866.—TERMINATION OF PROVIDER'S AGREEMENT—WITHHOLDING A SEGMENT OF SERVICES FROM TITLE XVIII MEDICARE PATIENTS

HCFAR–79–7

A provider of health services participating under a title XVIII agreement—whether it is a hospital, skilled nursing facility, home health agency, or other health care facility—withholding a segment of its services which are ordinarily furnished to all patients generally, from patients who are Medicare beneficiaries, *held* in possible violation of its participation agreement, justifying termination thereof by the Secretary of Health, Education, and Welfare.

A question has been raised whether refusal by a provider of health services participatng as such under section 1866 of the Social Security Act, to provide Medicare patients with a segment of services which are ordinarily furnished by the provider to its patients generally, constitutes a breach of the provider's participation agreement. In one instance the provider, a home health agency, wished to adopt a policy whereby it would not accept medical insurance (Part B) enrollees for home health treatment plans; in another, a provider hospital wished to adopt a policy whereby it would restrict its outpatient physical therapy services to patients who were not Medicare beneficiaries.

An institution or organization which qualifies as a provider of services under section 1861 of the Act may participate and become eligible for payment under the title XVIII health insurance program if it files an agreement with the Secretary pursuant to section 1866(a)(1) of the Act. The provisions of this section pertain equally to provider services under Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance). Subsectiton (b) provides, as pertinent here, that the agreement may be terminated by the Secretary if he determines that:

> . . . (A) such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861 . . . .

When a home health agency agrees to participate in the program, the agreement commits the agency to participate fully and not just in those situations where it is convenient or expedient to do so. The provisions of section 1866(a)(1) of the Act pertain equally to provider services under Part A and Part B, and refusal by the agency to treat Part B enrollees constitutes a breach of its section 1866 agreement to participate in the title XVIII program. There might be a valid explanation in an individual case, but a general policy of refusing services covered only under Part B is not acceptable. For example, in the absence of a general policy applicable to all patients, Medicare and non-Medicare, a hospital-based home health agency may not properly limit its services to Part A post-hospital patients and thereby exclude all Part B enrollees who had not had prior hospitalization. Home health services are defined in section 1861(m) of the Act and are

identical under Part A and Part B.

An agency does not provide Part A or Part B home health services, it provides simply—home health services. A beneficiary may be entitled to coverage under Part A or Part B or both, but the home health services furnished to him are the same services regardless of whether they are covered under Part A or Part B. As stated in section 1861(m):

> The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan * * * established and periodically reviewed by a physician, which items and services are . . . provided on a visiting basis in a place of residence used as such individual's home—* * *.

Since there is no distinction between Part A and Part B in the statutory definition of home health services, this practice would be a discrimination within the title XVIII program for which there is no suitable explanation or rationale. An agency policy of restricting services to Part A post-hospital patients would not, in the absence of a general policy applicable to all patients, Medicare and non-Medicare, be a sufficient justification for excluding Part B enrollees because home health services are covered under Part B after the individual has exhausted his Part A entitlement to post-hospital home health services. Thus, the status of an individual at the time when he receives services is determined by factors wholly unrelated to the reservations granted to a provider in section 1801 of the Act to operate free from supervision or control over the manner in which services are provided or over its administration and operation. Whether payment is under Part A or Part B is determined by operation of the Act and the agreement of the provider filed pursuant thereto, taking into account such factors as the limit on utilization under Part A or the requirement of prior hospitalization. Neither of these factors bears on the selection of Medicare patients by the provider.

For example, if a beneficiary is found, even after the rendition of home health services by a home health agency, to have exhausted his 100 visits by virtue of the receipt of earlier visits within the year from another agency, the second agency can be paid under Part B for only 80 percent of the cost of the subsequent visits, subject to the annual deductible, and, further, is required to accept such payment under the program. The coverage of home health services under either part of title XVIII thus bears no relation to a process of Medicare patient selection or rejection by a provider which may only be in conformity with the provider's commitment to accept payment for covered services in accordance with section 1866(a)(1) of the Act.

If adopted, such a policy would appear to be a subterfuge to circumvent the agency's commitment under its section 1866 agreement. The gist of the provider agreement is to participate under title XVIII, not just Part A of title XVIII. As stated in section 1866(a)(1): "Any provider of services shall be qualified to participate *under this title* and shall be eligible for payments *under this title* if it files with the Secretary an agreement—* * *." (Emphasis supplied.) Admittedly, for example, it would be easier for a provider not to be bothered with deductibles and coinsurance under Part B, but these considerations are not valid grounds for discriminating against

Part B enrollees. If a substantial number of home health agencies were to adopt such a procedure, the value of the Part B benefit would be significantly reduced.

In summary, if a home health agency provides and is reimbursed for services under Part A it cannot, in the absence of a general policy applicable to all patients, Medicare and non-Medicare, refuse to provide services under Part B. Failure to do so should be regarded as a violation of the provider agreement, which if not corrected, would justify a termination action by the Secretary.

In the second situation, the provider is a participating hospital which wishes to adopt a policy of restricting outpatient physical therapy services to non-Medicare patients. For the following reasons, this is also in violation of its participation agreement which would support a termination action by the Secretary under section 1866(b)(2) of the Act cited above.

The term "hospital" for purposes of the Medicare program, is defined in section 1861(e) of the Act. As the term is defined therein, the institution must establish that it meets certain specified criteria of service furnished uniformly to *all* patients. For example, under section 1861(e)(2) the "hospital" must maintain clinical records on *all* patients. Paragraph 4 of the definiton, moreover, requires that every patient must be under the care of the physician, and paragraph 5 sets forth the requirement for round-the-clock nursing services available to the patients of the hospital without exception. An institution, therefore, which withholds some segment of its services from a class of patients it has accepted for care and treatment would fail to meet the definition of the term "hospital."

This point is more clearly demonstrable by reference to the definition of "inpatient hospital services" in section 1861(b)(2) of the Act, wherein it is stated that "inpatient hospital services" includes "such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients * * *." The conclusion must be drawn from the foregoing, in accordance with its exact terms, that an institution which discriminates among its inpatients with regard to the services which constitute inpatent hospital services, would not be providing services as contemplated by the law and, therefore, would be unable to meet the definitional requirement in section 1861(e)(1) of the Act. While the fact pattern here pertains to outpatient physical therapy services, the principle applies with equal force to inpatients and outpatients of a provider of services. No Medicare patient may have withheld from him services ordinarily provided by the health care institution to its patients generally if the institution is to qualify or remain qualified as a provider of services.

(X–refer to SSR 72–38)

SECTIONS 1814(a)(3), 1861(b), 1861(e), and (1862(a)(1) (42 U.S.C. 1395 et seq.)—HOSPITAL INSURANCE BENEFITS—REASONABLE AND NECESSARY SERVICES—TEAM APPROACH IN REHABILITATION SERVICES

HCFAR–79–8a

Where following a cerebrovascular accident with right hemiplegia and aphasia, claimant for hospital insurance benefits required and received as an inpatient of a rehabilitation hospital intensive rehabilitation services requiring a multi-disciplinary coordinated team approach to upgrade her ability to function as independently as possible, *held,* payment may be made since such services were required to be given on an inpatient hospital basis and were therefore reasonable and necessary for treatment of claimant's illness.

W, the claimant, was admitted to Hospital A on September 23, 1970, with a sudden onset of aphasia and right-sided hemiplegia, and remained there during the acute period of her illness. On October 19 she was transferred to X Rehabilitation Hospital where she remained until discharged on December 19, 1970.

At issue is whether payment may be made on W's behalf for the services furnished her by the X Rehabilitation Hospital for the period October 19, 1970, to December 19, 1970. The specific issue is whether it was medically necessary for her to receive treatment or diagnostic study as an inpatient in a hospital.

Section 1814 of the Social Security Act provides in part:

(a) Except as provided in subsection (d), payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

* * *

(3) with respect to inpatient hospital services . . . which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose . . .

Section 1861(b) of the Act defines the term "inpatient hospital services" as the following items and services furnished to an inpatient of a hospital and by the hospital—

"(1) bed and board;

"(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital, or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

Section 1861(e) of the Act defines the term "hospital" as an institution which—

> (1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

Upon admission to X Hospital, the physical examination rendered an impression of cerebrovascular accident with right hemiplegia, aphasia, and hypertension. On October 22 W was examined by a member of the hospital's Department of Physical Medicine and Rehabilitation. His general findings show that she was totally aphasic with poor trunk balance and rightsided hemiplegia with right facial palsy; however, it was his impression that the onset was too recent to set up a prognosis in terms of recovery. The patient was to be placed on a combined physical, occupational, and speech therapy program and would be re-evaluated within 3 to 4 weeks.

Her first *speech therapy* evaluation was done October 23, 1970. The therapist felt prognosis for return of functional language was poor; however, she felt a trial period of therapy was warranted because of the inconsistent comprehension and the recent occurrence of the cerebrovascular accident. The claimant was scheduled for daily speech therapy and responded well to the first week of therapy. It is noted that at the time of evaluation her speech was usually limited to "yeh," but at the end of the first week, she was able to read words aloud and repeat a sentence although there were articulation errors. A marked change in alertness and general physical condition after 2 weeks of therapy suggested a need for re-evaluation. This was done November 10 and 11, and she showed improvement in auditory comprehension and increased verbalization.

The initial *physical therapy* evaluation shows the claimant needed much assistance in wheelchair management. She could come to a standing position in the parallel bars with assistance but required the assistance of two people to ambulate on them. Her balance in a standing position was only fair, which appeared to be related to muscle weakness rather than a real balance problem. A continued program of gait training was instituted. The physical therapy discharge summary indicates the claimant received physical therapy from October 21 to December 18, 1970, consisting of tilt table and progressing to ambulation. At the time of discharge, she ambulated up to 40 feet with the aid of a four-pronged cane and supervision. She required some assistance ascending and much assistance descending stairs. Difficulty getting out of her wheelchair persisted, but she could accomplish this with assistance.

An *occupational therapy* self-care evaluation was done on October 22, 1970. Her level of performance indicated almost total dependence; however, a self-care program including wheelchair transfers, eye-hand coordination, passive range of motion and active exercises where needed was instituted. Slow but steady progress was noted on November 3. In addition, the claimant expressed a desire to look better; therefore, it was decided to have her begin work on make-up application. By November 18 she could ambulate

in physical therapy with the aid of a walker and moderate assistance. By December 10 she still needed assistance with dressing upper and lower extremities, but wheelchair transfers had improved. The occupational therapy discharge summary indicates the claimant had become capable in feeding herself, she required supervision in grooming and bathing, she could dress herself for the most part, and she needed supervision in wheelchair transfer.

A patient is considered to require a hospital level of inpatient care if he needs a relatively intensive rehabilitation program consisting of a multidisciplinary coordinated team approach to upgrade his ability to function as independently as possible. A program of this scope usually includes intensive skilled rehabilitation nursing care, physical therapy, occupational therapy and, if nedeed, speech therapy. Upon admission, an assessment should be made of the patent's medical condition, attitude toward rehabilitation, functional limitations and prognosis. A decision should then be made whether rehabilitation is possible, what reasonable goals are, and how these goals are to be achieved. There need not be an expectation of the attainment of complete independence in the activities of daily living but there must be an expectation of an improvement that would be a practical benefit to the patient.

It is noted that the claimant spent 26 days at the initial hospital where she was treated during the acute stage of her illness due to a cerebrovascular accident which resulted in right hemiparesis and aphasia. The attending physician felt the claimant was a good candidate for rehabilitation as evidenced by his certification and recertification, and his statement dated September 20, 1971. He had the claimant transferred to the X Rehabilitation Hospital for specialized rehabilitation care. It was his opinion that the services she required could not be obtained in a skilled nursing facility. The record shows that her general condition had stabilized, but she did require intensive rehabilitative services consisting of various paramedical disciplines. Shortly after admission, a consultation was done by a specialist in physical therapy medicine and rehabilitation. A decision was made to place the claimant on a combined physical, occupational, and speech therapy program and re-evaluate her progress within 3 to 4 weeks. Although the record does not specifically state the goals they hoped to attain, it can be inferred that the goal was to attain a reasonable level of independence with activities of daily living.

The rehabilitation team met on November 6, December 4, and December 18, 1970. On the first two occasions, it was decided to continue therapy because satisfactory progress was noted. On November 18 and on December 9, 1970, the utilization review committee recommended continued hospitalization because maximum rehabilitation had not yet been attained. The attending physician certified and recertified that hospitalization was required because he felt the claimant had good rehabilitation possibilites. On December 18, however, it was felt that maximum progress had been made. Accordingly, the claimant was discharged the following day. The opinions of the attending physician, the rehabilitation team, and the utilization review committee were that the claimant had good rehabilitation potential. In this instance, the Council is inclined to agree because there was, in fact, significant improvement which was of sufficient practical benefit to the claimant to justify treatment.

Therefore, on the basis that a concerted team effort was made by hospital medical personnel to rehabilitate the claimant, the inpatient rehabilitation hospital services were reasonable and medically necessary.

Accordingly, the Appeals Council *held* that payment may be made to X Rehabilitation Hospital on W's behalf under title XVIII of the Social Security Act for services rendered during the period October 19 to December 19, 1970.

(X–refer to SSR 74–34a)

SECTIONS 226 and 1836; P.L. 89–97 (79 STAT. 286), SECTION 103.—HOSPITAL INSURANCE BENEFITS AND SUPPLEMENTARY MEDICAL INSURANCE BENEFITS—LAWFULLY ADMITTED ALIEN NOT RESIDENT IN THE UNITED STATES FOR 5 YEARS

42 CFR 405.102, 405.103 HCFAR–79–9

An alien, born in 1898, was lawfully admitted to the United States for permanent residence on March 3, 1962, and resided in the United States continuously from that date. On December 15, 1965, she filed application for entitlement to hospital insurance benefits. She was not entitled to a monthly insurance benefit under section 202 of the Social Security Act nor was she a qualified railroad retirement beneficiary as defined in section 226 of the Act, nor had she resided in the United States continuously for 5 years immediately preceding the month she filed application, as required by section 103(a)(4)(B) of Public Law 89–97 (the Social Security Amendments of 1965). *Held*, such alien is neither entitled to hospital insurance benefits nor eligible to enroll for supplementary medical insurance benefits.

R, an alien, born in 1898, was lawfully admitted to the United States for permanent residence on March 3, 1962. She has resided continuously in California since the month of her entry into the United States. On December 15, 1965, at age 67, R filed an application for entitlement to hospital insurance benefits, enrollment in the supplementary medical insurance program, and for monthly insurance benefits under section 202 of the Social Security Act.

R was found not to be entitled to monthly insurance benefits under section 202 of the Act and not to be a qualified railroad retirement beneficiary.

The questions to be resolved are whether R is entitled to hospital insurance benefits on the basis of the application she filed on December 15, 1965, and whether such application constitutes an effective enrollment in the supplementary medical insurance program.

Section 226 of the Social Security Act, as added by section 101 of Public Law 89–97 (the Social Security Amendments of 1965), provides, as pertinent here, that:

(a) Every individual who—
(1) has attained the age of 65, and
(2) is entitled to monthly insurance benefits under section 202 or is a

qualified railroad retirement beneficiary,

shall be entitled to hospital insurance benefits * * * for each month for which he meets the condition specified in paragraph (2), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2).

Although R attained age 65 at the appropriate time, she was not entitled to monthly insurance benefits and was not a qualified railroad retirement beneficiary and, therefore, does not meet the requirements of section 226(a) of the Act.

However, under section 103(a) of P.L. 89–97, a person who is not entitled to a monthly insurance benefit under section 202 may nevertheless become entitled to hospital insurance benefits if certain requirements are met. Section 103(a) provides as pertinent here:

Anyone who—

(1) has attained the age of 65,

(2) (A) attained such age before 1968, * * *,

(3) is not, and upon filing application for monthly insurance benefits under section 202 of the Social Security Act would not be, entitled to hospital insurance benefits under section 226 of such Act, * * *,

(4) is a resident of the United States (as defined in section 210(i) of the Social Security Act), and is (A) a citizen of the United States or (B) an alien lawfully admitted for permanent residence who has resided in the United States (as so defined) continuously during the 5 years immediately preceding the month in which he files application under this section, and

(5) has filed an application under this section in such manner and in accordance with such other requirements as may be prescribed in regulations of the Secretary,

shall * * * be deemed, solely for purposes of section 226 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning with the first month in which he meets the requirements of this subsection * * *

R satisfies all the foregoing requirements of section 103(a) except for paragraph (4). She is a resident of the United States, but not a citizen. She is an alien who was lawfully admitted to the United States for permanent residence but she did not reside in the United States during all of the 5-year period immediately preceding the month (December 1965) in which she filed her application. Such 5-year period began with December 1960 and ended with November 1965. R, however, did not enter the United States until March 3, 1962. Consequently, R does not satisfy the 5-year residence requirement of section 103(a)(4)(B) or the citizenship requirement of section 103(a)(4)(A).

R's December 1965 application was also an application for enrollment in the supplementary medical insurance program established by Part B of title XVIII of the Social Security Act. Section 1836 of title XVIII of the Act provides:

Every individual who—

(1) has attained the age of 65, and

(2) (A) is a resident of the United States, and is either (i) a citizen or (ii) an alien lawfully admitted for permanent residence who has re-

sided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part [Part B of title XVIII, "Supplementary Medical Insurance Benefits for the Aged," sections 1831–1844 of the Act], or (B) is entitled to hospital insurance benefits under part A [Part A of title XVIII, "Hospital Insurance Benefits for the Aged," sections 1811–1817 of the Act],

is eligible to enroll in the insurance program established by this part.

R does not satisfy the requirements of paragraph (2) of section 1836 of title XVIII because she neither is entitled to hospital insurance benefits, nor is she a citizen of the United States, nor did she reside in the United States during the 5-year period preceding December 1965, the month in which she filed application.

Accordingly, it is *held* that on the basis of her application of December 15, 1965, R is not entitled to hospital insurance benefits and, furthermore, she is not eligible to enroll in the supplementary medical insurance program.

(X–refer to SSR 67–29)

SECTIONS 1814(e) and 1870.—RECOVERY OF PAYMENT TO PROVIDER OF INPATIENT HOSPITAL SERVICES—SERVICES FURNISHED BY PROVIDER PRIOR TO NOTIFICATION THAT BENEFICIARY LACKS ENTITLEMENT

HCFAR–79–10

Payment made to a hospital-provider under section 1814(e) as reimbursement for its reasonable costs in furnishing inpatient hospital services to a Part A beneficiary prior to notification to the hospital that he lacked entitlement thereto, *held* not subject to reduction for coinsurance amounts; *held,* further, such payment constitutes an overpayment to the beneficiary on whose behalf payment was made, which is recoverable from him in accordance with section 1870 of the Act, subject to waiver in certain instances.

Section 1814(e) of the Social Security Act provides in pertinent part that:

Notwithstanding that an individual is not entitled to have payment made under this part (Part A of title XVIII of the Act) for inpatient hospital services furnished by any hospital, payment shall be made to such hospital . . . for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement if such payments are precluded only by reason of section 1812 and if such hospital complies with the requirements of and regulations under this title with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for the services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or legal holiday) after the day on which such admission occurred.

As provided in pertinent part by section 1812 of the Act, cited above, a beneficiary under Part A is entitled to have payment made on his behalf for inpatient hospital services for up to 150 days during any spell of illness. Payment may not, however, be made on his behalf for such services "furnished to him during such spell after such services have been furnished to him for 150 days during such spell * * *."

Advice has been requested in a situation where a provider-hospital makes a claim for payment based on the "guarantee" provisions of section 1814(e) cited above. A Part A beneficiary with only 2 days of inpatient service utilization remaining in his current spell of illness was admitted to the hospital and was furnished inpatient hospital services for 9 days. The hospital was not notified, until after the patient had been discharged, of his 2 remaining days of utilization. While it is not disputed that payment may be made to the hosptal under section 1814(e), the purpose of which is to protect a hospital in such cases, two specific questions have been raised about the scope of this section:

(1) Is the payment to the hospital pursuant to section 1814(e) subject to reduction for the coinsurance amount? and

(2) Can the amount paid be recovered from the beneficiary under the overpayment provisions of section 1870 of the Act?

Section 1814(e) of the Act is predicated upon the understanding that the individual has exhausted his benefits in a spell of illness and is no longer entitled to inpatient hospital service in that spell of illness. The payment authorized thereunder is not pursuant to section 1812 of the Act, cited above, but notwithstanding such section. It provides for an additional assumption of liability by the program in the circumscribed situation to which it relates. Since the payment to be made is for inpatient hospital services furnished by the hospital at a time when the beneficiary is *not* entitled to benefits, the only measure of payment under the program is that stated in section 1814(b) of the Act, namely, the reasonable cost of the services furnished.

This measure of payment is clearly distinguishable from the measure of payment applicable where the hospital is being reimbursed for services it furnished the beneficiary during the 2 remaining days of utilization to which he *was* entitled during the spell of illness. The hospital must be paid its reasonable costs for providing service for these days, reduced by the coinsurance amount provided in title XVIII of the Act, with respect to each day after the 60th day and before the 151st day of inpatient hospital service. The coinsurance reduction of benefit payment is limited only to that period of *covered* inpatient hospital services including, in this case, the beneficiary's remaining days of utilization, and is, in effect, a condition imposed upon those services. Coinsurance is a sharing by the program and the beneficiary of the cost of service which the beneficiary is entitled to receive.

The second question for determination is whether a payment made to a provider pursuant to section 1814(e) of the Act may be recovered under the overpayment provisions of section 1870 of the Act. Section 1870 provides in pertinent part as follows:

(a) Any payment under this title to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

(b) Where—

(1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that * * * the excess over the correct amount cannot be recouped from such provider or other person, or (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or

(2) any payment has been made under section 1814(e) to a provider of services or other person for items or services furnished an individual, proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—

(3) to which such individual is entitled under title II of this Act or under the Railroad Retirement Act of 1974, as the case may be, or

(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under title II of this Act or under the Railroad Retirement Act of 1974, as the case may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under title II of such Act.

(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (*including payments under section 1814(e)*) with respect to an individual who is without fault or where the adjustment (a recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if such adjustment (or recovery) would defeat the purpose of title II or title XVIII or would be against equity and good conscience. (Underscoring supplied.)

A payment made to a provider pursuant to section 1814(e) of the Act is also considered as a payment to the beneficiary on whose behalf it was made. While recoupment, as provided in subsection (b)(1) cited above, would not be applicable because such payment was not an incorrect payment to the recipient provider as an unauthorized payment would be, nevertheless, the payment would be an incorrect payment with respect to the beneficiary. Thus, all the remedies for recovery of an overpayment otherwise available to the Administration can be exercised to bring about recovery of such payment directly from him. Any question with regard to the purpose of subsections (a) and (b)(2) is resolved through reference to subsection (c) relating to waiver of recovery, where the distinction in procedure between recoupment from a provider and recovery from a beneficiary is noted specifically, and, further, the section 1814(e) payment is designated as an "incorrect payment" for purposes of recovery procedures against beneficiaries.

(X–refer to SSR 67–73)

SECTIONS 1814(f) and 1862(a)(4).—HOSPITAL INSURANCE BENEFITS—EMERGENCY INPATIENT HOSPITAL SERVICES IN HOSPITALS OUTSIDE THE UNITED STATES

42 CFR 405.153, 405.313 HCFAR–79–11

Held, section 1814(f) of the Act, which provides that under certain conditions emergency inpatient hospital services rendered outside the United States are covered under Part A of title XVIII, permits payment to be made where the insured individual is inside the United States near a foreign border when a medical emergency requiring hospitalization occurs, the individual leaves the United States to obtain treatment, and the nearest or most accessible hospital is across the border. *Further held,* payment may not be made under section 1814(f) for emergency hospital services rendered outside the United States where the individual left the United States for purposes other than to obtain medical treatment, even though the medical emergency occurred within the United States; nor will payment be made for emergency inpatient hospital services in foreign countries not geographically adjacent to United States territory.

Section 1862(a) of the Social Security Act excludes from coverage under the health insurance program established by title XVIII of the Act all expenses incurred for items or services—

* * * * * * *

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in sections 1814(f) * * *).

Section 1814(f)(2), as pertinent, provides as follows:

(2) Payment may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States if—

(A) such individual was physically present—

(i) in a place within the United States; * * * at the time the emergency which necessitated such inpatient hospital services occurred; * * * and

(B) such hospital was closer to, or substantially more accessible from such place than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

A question has arisen as to when emergency inpatient hospital services in a foreign hospital are covered under the provisions of section 1862(a)(4) and 1814(f), supra, where the insured individual while on a vacation or business trip was taken sick or injured immediately after boarding a plane or ship departing the United States and had no opportunity to disembark until reaching the foreign country. The resolution of this question depends, in part, on the meaning of the phrase "physically present in a place within the United States" which occurs in section 1814(f)(1), supra.

The term "United States" is defined by sections 1861(x) and 210(i) of

the Act as meaning the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa; by reference to precedents establishing American territorial limits,[1] the term also includes American territorial waters and the airspace above such waters.

However, the phrase "physically present in a place within the United States" should be interpreted in view of its context and legislative background. Section 1814(f)(2), in specifying that the foreign hospital be closer to the place where the medical emergency occurred or more accessible than the nearest adequately-equipped and available hospital in the United States, contemplates the situation where an emergency occurs relatively close to a foreign border (e.g., the Canadian frontier), and a physician or other responsible person could not conscientiously permit the delay which would be entailed in sending the individual to a hospital in the United States. Another requirement of section 1814(f), implicit but obvious, is that the medical difficulty be a genuine emergency.

The sequence thus required by the statute is that an individual suffer an emergency medical situation while he is within the United States, and that he leave the United States for the purpose of obtaining emergency hospital treatment in a foreign hospital because the foreign hospital either is closer than a hospital in the United States or is more accessible from the place within the United States where the emergency occurred.

Therefore, if the individual's reason for leaving the United States is to obtain prompt treatment at a hospital nearer, or more accessible, than the nearest adequate American hospital, his situation is clearly that contemplated by the statute. On the other hand, if his departure is part of a trip abroad, so that the hospital is more "accessible" simply because he was involved in the processes of such travel (e.g., the airplane on which he was traveling was already enroute and so could not readily return to permit his removal), the situation is not that contemplated by the statute, and in such a situation services in a foreign hospital would not be covered by section 1814(f) even though the individual was within the "United States" when the emergency occurred.

This construction of the statute is enforced by reference to the practical considerations unrestricted foreign coverage would present. Payment to Canadian or Mexican hospitals close to the border entails certain problems, yet these problems are insignificant when compared with those to which a broad extension of coverage in foreign hospitals would have, involving dealings with foreign hospitals separated from the United States by great barriers of distance, language, fiscal differences, and major variants in the level of medical care. It is likely that such practical considerations dictated the general exclusion, in section 1862(a)(4), of services not provided within the United States.

Accordingly, it is *held* that, other requirements being met, payment may be made under section 1814(f) of the Act for emergency inpatient hospital services rendered outside the United States where the insured individual is inside the United States near a foreign border when a medical emergency requiring hospitalizaton occurs, the individual leaves the

[1] *United States* v. *State of California*, 381 U.S. 139, 85 S. Ct. 1401 (1965); the Submerged Lands Act, 43 U.S.C. §§ 1301ff.; *C.A.B.* v. *Island Airlines, Inc.*, 235 F Supp. 990 (D. Hawaii, 1964); *Ross* v. *McIntyre*, 140 U.S. 453, 11 St. Ct. 897 (1891).

United States to obtain treatment, and the nearest or most accessible hospital is across the border. It is *further held* that payment may not be made under section 1814(f) of the Act for emergency inpatient hospital services rendered outside the United States where the individual left the United States for purposes other than to obtain medical treatment even though the medical emergency occurred within the United States; nor will payment be made for emergency inpatient hospital services in foreign countries not geographically adjacent to United States territory.

(X–refer to SSR 68–25)

SECTIONS 1836 and 1837.—HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE BENEFITS—ELIGIBILITY OF CERTAIN CUBAN REFUGEES

42 CFR 405.102 and 405.205(b) HCFAR–79–12

Where, under the provisions of P.L. 89–732 the Attorney General, upon application by a Cuban refugee, adjusts the status of such alien to that of alien lawfully admitted for permanent residence and records a date of such admission retroactively, *held* for purposes of determining when such alien met the lawful admission requirement under section 103(a) (4) of P.L. 89–97 for establishing entitlement to hospital insurance benefits under Part A of title XVIII of the Social Security Act, the retroactive date of admission recorded by the Attorney General governs; in determining when such alien met the lawful admission requirement under section 1836(2) (A) of the Social Security Act for establishing eligibility for enrollment for supplementary medical insurance benefits under Part B of title XVIII of the Social Security Act, the date the Attorney General adjusted such alien's status governs.

Public Law 89–732 (80 Stat. 1161), enacted November 2, 1966, added a provision to the Immigration and Nationality Act whereby the Attorney General may adjust the status of certain Cuban refugees to that of aliens lawfully admitted for permanent residence in the United States. Under the provisions of P.L. 89–732, as pertinent here, an alien's status may be so adjusted if he is a native or citizen of Cuba, has been physically present in the United States for at least 2 years, and makes application for this adjustment. If such alien was admitted as a refugee into the United States after January 1, 1959, and applies for adjustment of his status, the record of his admission for permanent residence will show a date 30 months prior to the date of the application or the date of his arrival into the United States, whichever date is later. If such alien was lawfully admitted into the United States for permanent residence before November 1, 1966, and makes application to have his date of lawful admission adjusted, the Attorney General shall record admission for permanent residence as of the date the alien originally arrived in the United States or May 1964, whichever is later.

Section 103(a) of Public Law 89–97 (the Social Security Amendments of 1965 (79 Stat. 286)) provides, as pertinent here, that a person age

65 or over who cannot meet the requirements of section 226 of the Act for entitlement to hospital insurance benefits under Part A of title XVIII because he is neither entitled to monthly benefits under section 202 of the Act nor a qualified railroad retirement beneficiary, may nevertheless become entitled to hispital insurance benefits, if, (among other requirements) he files an application and;

> (4) is a resident of the United States (as defined in section 210(i) of the Social Security Act), and is (A) a citizen of the United States or (B) an alien lawfully admitted for permanent residence who has resided in the United States (as so defined) continuously during the 5 years immediately preceding the month in which he files application under this section, * * *.

An application for hospital insurance benefits under section 103(a) may be effective retroactively for as many as 12 months before the month in which such application is filed. There is no provision for retroactivity of an application for supplementary medical insurance benefits.

Section 1836 of the Act provides that a person age 65 or over may enroll in the supplementary medical insurance program under Part B of title XVIII if he: * * *

> (2) has attained age 65 and is a resident of the United States and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment.

The question to be resolved is whether the retroactive date of lawful admission under P.L. 89–732 may be used for purposes of determining an uninsured alien's date of entitlement to hospital insurance benefits and for determining his enrollment period for supplementary medical insurance benefits.

The phrase "lawfully admitted for permanent residence." as found in section 103(a)(4) of P.L. 89–97 and section 1836(2)(B) of title XVIII, is a term of art adopted from the Immigration and Nationality Act, in section 101(a)(20) of which it is defined (8 U.S.C. 1101(a) (20)). Accordingly, the phrase has the same meaning in title XVIII as it does in the Immigration and Nationality Act. The Administration, in its determinations under sections 103 and 1836 is obliged to accept the determinations of the Attorney General and his delegates as to the fact of lawful admission, since only that official is authorized by statute to make such determinations.

Accordingly, there is no question as to the retroactive lawful admission status of the Cuban refugees for purposes of hospital insurance coverage under part A of title XVIII. The retroactive admission date, as determined by the Attorney General under P.L. 89–732, is controlling as to when the alien met the statutory requirement of lawful admission, so that if the alien meets all of the other requirements of coverage (including the filing of an application) he may be entitled to retroactive part A coverage for up to 12 months.

With respect to part B coverage, however, the question is more complex.

If we were to treat the Attorney General's retroactive admission date as controlling for purposes of establishing the date of eligibility to enroll under part B, the effect would be to delay rather than expedite the possibility of part B coverage for Cuban refugees who were the beneficiaries of P.L. 89–732.

Under part B, an individual has a limited period in which to enroll. If he fails to enroll in his initial enrollment period (a 7-month period that is based upon the date he first becomes eligible to enroll) he may have to wait until the following year to enroll and his coverage will be delayed accordingly. In addition, he may be required to pay an additional premium because of his late enrollment.

Thus, a rigid application of the retroactive provisions of P.L. 89–732 to part B of title XVIII would have the effect of denying the beneficiaries of that statute the opportunity to obain prompt part B coverage by imputing to them a fictitious failure to enroll in the initial enrollment period as determined retroactively. Such an interpretation would be contrary to the purposes of P.L. 89–732 and part B of title XVIII of the Social Security Act, both of which were intended to offer opportunities for coverage rather than obstacles to the parties affected by the legislation.

Accordingly, it is *held* that where the Attorney General, under P.L. 89–732, adjusts the status of a Cuban refugee to that of an alien lawfully admitted for permanent residence and records a retroactive date of lawful admission, such retroactive date is controlling in determining when the alien met the lawful-admission requirement of section 103(a)(4) of P.L. 89–97 for purposes of entitlement to hospital insurance benefits. It is *further held* that in determining when such alien met the lawful-admission requirement of section 1836(2)(B) of the Act for purposes of establishing his enrollment period for supplementary medical insurance benefits, the determinative date for lawful admission is not the retroactive recorded date of admission but the date on which the Attorney General actually adjusts the alien's status.

(X–refer to SSR 68–38)

SECTION 226.—HOSPITAL INSURANCE BENEFITS—ATTAINMENT OF AGE 65—EFFECT ON ENTITLEMENT TO POSTHOSPITAL EXTENDED CARE SERVICES

42 CFR 405.120 HCFAR–79–13

The claimant was an inpatient in a hospital from May 17, 1969, until discharged, and transferred to the skilled nursing unit of such hospital on May 26, 1969, where she remained through July 11, 1969. She attained age 65 and became entitled to hospital insurance under Part A of title XVIII of the Social Security Act in June 1969. *Held,* payment on her behalf for posthospital extended care services furnished her is precluded by section 226 of the Act, since the prerequisite qualifying hospital discharge did not occur on or after the first day of the month in which she attained the age of 65.

N, who was entitled to widow's insurance benefits, entered the O Hospital on May 17, 1969, and was discharged on May 26. She was immediately transferred to the skilled nursing unit of the hospital, where she remained until July 11, 1969. Meanwhile, in June 1969 she attained age 65 and became entitled to hospital insurance under Part A of title XVIII of the Social Security Act. N's claim for payment for the extended care services furnished by the skilled nursing unit, beginning June 1, 1969, has been denied, on the ground that the requirements of section 226 of the Act had not been met. N has protested this decision on the basis that since she is entitled to hospital insurance beginning June 1, 1969, payment should be made for the extended care services she received beginning with that day.

Section 226 of the Act provides, as pertinent here, that entitlement of an individual to hospital insurance *for a month* consist of entitlement to have payment made on his behalf for inpatient hospital services, posthospital extended care services, and posthospital home health services (as such terms are defined in Part C of title XVIII) furnished him during such month. His insurance coverage begins with the first day of the month in which the individual attains age 65, if he has applied for and been determined to be entitled to monthly social security benefits for that month. However, section 226(c)(1)(B) provides also that:

> no such payment may be made for post-hospital extended care services or post-hospital home health services *unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII** occurred after June 30, 1966, or *on or after the first day of the month in which he attains age 65, whichever is later*;—(Emphasis and footnote (*) supplied.)

It is not here contended that entitlement to payment on N's behalf existed for either the inpatient hospital services or the extended care services she was furnished during May 1969, the month before the month in which she attained age 65. At issue, however, is whether N is entitled to have payment made to the skilled nursing facility on her behalf for the extended care services she received beginning June 1, 1969, the first day of the month in which she attained age 65 and met the requirements of section 226.

The undisputed facts in this case show that N was hospitalized May 17, 1969, and remained an inpatient until May 26, 1969, when she was discharged to the hospital's skilled nursing facility. Since N's hospital discharge did not take place on or after the first day of the month in which she attained the age of 65, that is June 1, 1969, *held*, the provisions of section 226 of the Act preclude payment on her behalf for the extended care services furnished N from May 26, 1969, through July 11, 1969.

(X–refer to SSR 70–34)

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* Under pertinent terms of section 1861(i), payment for extended care services may be made only if such services were furnished by a facility to which the individual was transferred within 14 days after his discharge from a hospital in which the individual was an inpatient for not less than 3 consecutive days.

SECTION 1814(f).—HOSPITAL INSURANCE BENEFITS—EMERGENCY INPATIENT HOSPITAL SERVICES OUTSIDE THE UNITED STATES—EXCLUSION FROM COVERAGE

42 CFR 405.153 HCFAR–79–14

A hospital insurance beneficiary who went to Canada to visit his son suffered a stroke and was taken to the emergency room of a Canadian hospital. While it was alleged that he might have become ill while he slept in the car between the United States and Canada, the hospital admission record showed that the sudden onset of symptoms which necessitated his immediate hospitalization was not detected until he reached the son's home. *Held,* reimbursement for the emergency hospital inpatient services furnished by the Canadian hospital is precluded, since the beneficiary was not physically present in a place within the United States when the emergency necessitating such hospital services occurred, as required by section 1814(f)(2) of the Social Security Act. *Further held,* since he left the United States for purposes other than to obtain medical treatment, payment is precluded by the requirements of section 1814(f)(2) of the Act.

G, an 82-year-old individual entitled to hospital insurance benefits under Part A of title XVIII of the Social Security Act, suffered a stroke and was admitted as an inpatient to the H Hosptal in Canada. G remained in the Canadian hospital 52 days before he was transferred to a hospital within the United States for further care. G's son paid the bill presented by the H Hospital totaling $1,651 and has filed a claim for reimbursement, pursuant to the provisions of section 1814(f) of the Act.

The benefits provided an individual by the health insurance program under title XVIII of the Act allow payment to be made for hospital and medical services, subject to certain exclusions and limitations contained in the Act. One such exclusion, contained in section 1862(a) of the Act, provides that no payment will be made under the health insurance program for any expenses incurred for items or services—

* * * * * * *

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in sections 1814(f) * * *).

Section 1814(f)(2), as pertinent, provides as follows:

(2) Payment may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States if—

(A) such individual was physically present—

(i) in a place within the United States; * * * at the time the emergency which necessitated such inpatient hospital services occurred; * * * and

(B) such hospital was closer to, or substantially more accessible from such place than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

It has not been disputed that G received *emergency* inpatient hospital services at the H Hospital in Canada. The issue to be resolved, however, is whether these services occurred under the conditions described in section 1814(f) quoted above, thus constituting covered services for which reimbursement under title XVIII may be made.

The resolution of this question depends on a determination as to whether the emergency arose while G was "physically present in a place within the United States" and whether he was taken to the Canadian hospital because it was closer or more accessible from such place than the nearest hospital within the United States which was adequately equipped and available for treatment of the emergency. These requirements of section 1814(f) are discussed in HCFA Ruling No. 79–11, P. . Said ruling, which concerned the claim of a health insurance beneficiary who was stricken while enroute to a foreign country on an airplane and had no opportunity to disembark for hospitalization until the plane landed, held:

> Other requirements being met, payment may be made under section 1814(f) of the Act for emergency inpatient hospital services rendered outside the United States where the insured individual is inside the United States near a foreign border when a medical emergency requiring hospitalization occurs, the individual leaves the United States to obtain treatment, and the nearest or most accessible hospital is across the border. It is further held that payment may not be made under section 1814(f) of the Act for emergency inpatient hospital services rendered outside the United States where the individual left the United States for purposes other than to obtain medical treatment even though the medical emergency occurred within the United States; nor will payment be made for emergency inpatient hospital services in foreign countries not geographically adjacent to United States territory.

The relevant evidence in this case, including statements by G's family as indicated in the hospital's admission record, shows that when G arrived at his son's home in Canada, alarm over a sudden onset of symptoms necessitated his removal to the Canadian hospital's emergency room. His symtoms included dizziness, vomiting, and numbness in the left leg and arm and drooping of the left side of the face. On admission he was comatose with stertorous breathing, constricted pupils and rales through both lungs. His condition was then diagnosed as possible right arteriothrombosis with left hemiplegia, atherosclerotic heart disease with congestive heart failure.

The hospital record is silent regarding an allegation made by G's family that he may have become ill while asleep in the car while enroute to Canada. Nor does the record mention the possibility of a casual relationship between G's alleged "sleep" and the medical emergency. It is reasonable to assume that if the sleeping episode was medically significant as alleged, this information would have been conveyed to the hospital and incorporated into the medical record. The weight of the credible medical evidence, including that obtained from G's family, establishes that the emergency which necessitated G's immediate hospitalization in Canada did not occur while he was physically present within the United States nor is there any indication that the purpose of his trip to Canada was to obtain treatment for his condition. In fact, the hospital records upon admission indicate a sudden onset of symptoms in Canada, one or two hours prior to admission to the emergency room.

Since the emergency inpatient hospital services furnished G by the H Hospital in Canada do not meet requirements (1) and (2) of section 1814(f) of the Social Security Act, *held,* they do not constitute covered services for which reimbursement under title XVIII may be made.

(X–refer to SSR 70–50)

SECTION 1861(v)(2).—HOSPITAL INSURANCE—MEDICAL NECESSITY—BENEFICIARY REQUEST FOR PRIVATE ROOM ACCOMMODATIONS

42 CFR 405.116(b) HCFAR–79–15

An individual entitled to hospital insurance benefits was admitted to a two-bed room in a hospital, underwent ulcer surgery, and was thereafter transferred to a private room because of his request. *Held,* (1) the furnishing of a private room at the request of the patient (or his family) and in absence of an order from the physician on grounds of medical necessity is not "required for medical reasons" and (2) Medicare payment may not be made to the hospital on his behalf for that part of the cost of the private room in excess of the reasonable cost of semiprivate accommodations merely because of a statement made by his physician several months after his recovery and discharge that his condition made the use of a private room medically necessary.

N, a 79-year-old individual entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act, was admitted to a hospital emergency room on March 30 because of several episodes of unconsciousness at home. He complained of pain in the stomach and back. He was placed in a two-bed room. The admitting diagnosis was probable duodenal ulcer. Surgery was performed April 1. A large duodenal ulcer was found, and a vagotomy and gastrojejunostomy (abdominal resection) were done. N was transferred to a private room, where he remained until discharged from the hospital April 25. Payment for inpatient hospital services provided N by the hospital was approved by the Social Security Administration (now Health Care Financing Administration) with the amount of approved payment being equal to the reasonable cost of such services furnished in semiprivate accommodations. The hospital has billed N for $264, which represents the differential ($11 per day) between its customary charges for private and semi-private accommodations for the 24 days he occupied a private room. Such a charge is permitted by section 1866(a)(2)(B) where a hospital furnishes a patient, at his request, a service more expensive than is covered under title XVIII. N has protested this decision, contending that he feels a private room was medically necessary, and therefore his hospital insurance under title XVIII should pay the full reasonable cost of his private room, and the hospital has no right to charge him for any item or service for which payment in full is made under title XVIII.

According to the hospital records, N was transferred to a private room on April 1, and the reason for such transfer was given as "patient requested

private room." N stated that he made the request for a private room in the belief that it was medically necessary. On that day, surgery had been performed and the hospital records reveal that N tolerated the procedure well and his postoperative condition was "stable and satisfactory." Following the operation, N's recuperative period was uneventful until April 6, when he became dizzy on sitting up and complained of pain in right lower chest. On April 7, 6 days after the operation, it was determined that he had a pulmonary embolus, and it was necessary to prescribe the anticoagulate, coumadin; it was discontinued April 9, but later resumed. As of April 10, N was "improving." The following day irrigation was initiated by use of a catheter which was later removed on April 17. Following that, his condition continued to improve until he was discharged to his home on April 25. Approximately 3 months after his discharge, in support of his protest against the bill of $264, his attending physican submitted a statement that, in his opinion, a private room was medically necessary because of the severity of N's condition and the consequent need for care and nursing by his family.

The benefits provided to an individual by the hospital insurance program under part A consist of entitlement to have payment made on his behalf for inpatient hospital services for up to 90 days during a benefit period plus a 60-day lifetime reserve. The term inpatient hospital services includes bed and board. The measure of program responsibility for the cost of bed and board is set forth in section 1861(v)(2)(A) of the Act as follows:

> If the bed and board furnished as part of inpatient hospital services . . . is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

Whether or not title XVIII payment may be made for the full cost of the private room depends upon whether N required a private room for "medical reasons," as that term is used in section 1861(v)(2)(A), supra.

Section 405.116(*b*) of Health Care Financing Administration Regulations (42 CFR 405.116(b)) which sets out the items and services considered as "covered" inpatient services, provides in part as follows:

> *Bed and Board.* The reasonable costs are payable in full for hospital room and board furnished an individual in accommodations containing from two to four beds, or in hospitals in which all accommodations are on a ward basis and charges are not related to the number of beds in a room. The reasonable cost of private accommodations is covered in full only where their use is medically indicated, ordinarily only when a patient's condition requires him to be isolated or when an individual (in need of immediate inpatient hospital care but not requiring isolation) is admitted to a hospital which has no semi-private or ward accommodations, or at a time when such accommodations are occupied . . . until the individual's condition does not require him to be isolated or, in the case of the individual not requiring isolation, semi-private accommodations are available. Where private accommodations are furnished for a patient's comfort, the amount payable under this Subpart A may not exceed the reasonable cost of accommodations containing from two to four beds. . . .

Under the Regulations, § 405.610 (42 CFR 405.610), a provider of services may not charge for items where the cost of such items is paid in full by Medicare. However, the provider may charge for items not covered or more expensive than those covered, if the patient requests such noncovered or expensive items with knowledge of the amount to be charged.

Since, under the facts in this case, semi-private accommodations were available, medical necessity for N's use of a private room may be found to exist only if N's condition required him to be isolated. However, there is nothing in the hospital records or in the statements by the attending physician which indicate that it was necessary to have N isolated; he did not have a communicable disease; he did not have symptoms, nor did he receive treatment, likely to alarm or disturb others in the same room. The severity of a patient's condition does not demonstrate need for isolation, nor does the need for nursing care. It is also noted that the hospital records show that N requested the private room. While the attending physician submitted a statement some months after N's discharge attesting to the medical necessity for the private room, the evidence shows that the private room was furnished, not on doctor's orders based on the need for isolation, but at N's request; and the room was occupied not until isolation was no longer necessary, but until N was discharged. Assuming that N needed continued care and nursing by his family, there is no reason why the family could not have been in attendance in a two-bed room as well as in a private room.

Where a private room is furnished, not on grounds of medical necessity as indicated above and as ordered by the physician, but because of the request of the patient or his family, the amount payable under the Medicare program may not exceed the reasonable cost of semi-private accommodations. A physician's statement of medical necessity written some time after the admission may serve to confirm his verbal order for the private room given at or before the time of admission, but may not substitute for such a timely order.

Accordingly, it is *held,* since the private accommodations were furnished at N's request and were not medically necessary, payment of hospital insurance benefits may not be made on his behalf for that part of the cost of a private room which was in excess of the reasonable cost of semi-private accomodations at the hospital where he was treated from March 30 through April 25.

(X–refer to SSR 71–50)

SECTIONS 217(a) and 226(e)–(f) (42 U.S.C. 417(a) and 426(e)–(f))––HOSPITAL INSURANCE BENEFITS—CHRONIC RENAL DISEASE—USE OF DEEMED WAGES TO ESTABLISH FULLY INSURED STATUS—EFFECT OF BENEFIT FROM OTHER FEDERAL AGENCY ON HOSPITAL INSURANCE ENTITLEMENT

20 CFR 404.1301(a) and 42 CFR 405.104(a) and (b)

HCFAR–79–16

Where use of section 217 "deemed wages" based on active military service during World War II is necessary to establish fully insured status for purposes of entitlement to hospital insurance benefits on the basis of chronic renal disease under section 226, *held,* their use is not precluded by the language in section 217 and such "deemed wages" may be used in determining insured status for Medicare; *further held,* where benefit is determined to be payable to individual by U.S. agency or instrumentality on basis of the same active military service which has enabled individual to be deemed to have received wages under section 217(a) and receive insured status for purposes of Medicare eligibility, redetermination with respect to individual's insured status for purposes of determining whether Medicare eligibility may continue, would not be required by section 217(a)(1)(B) of the Act.

R, the wage earner, has chronic renal disease and has been receiving hemodialysis on a regular basis since June 1973. In order to be "deemed disabled" under section 226(e)(2) for purposes of eligibility to hospital insurance on the basis of chronic renal disease, an individual must be *inter alia:*

> "(A) . . . fully or currently insured (as such terms are defined in section 214 of [the] Act, or (B) . . . entitled to monthly insurance benefits under title II of [the] Act, or (C) . . . the spouse or dependent child (as defined in regulations) of an individual who is fully or currently insured, or (D) . . . the spouse or dependent child (as defined in regulations) of an individual entitled to monthly insurance benefits under title II of [the] Act . . ."

The only means by which the subject wage earner could meet the above requirement is by being fully insured as defined in section 214. Section 214(a) provides that an individual would be "fully insured" if he has acquired within the prescribed time a specified number of quarters of coverage. The wage earner had only a few quarters of coverage since most of his employment had been under civil service and he could meet the fully insured status requirement only by using his military service wage credits for World War II service. Section 214, however, makes no reference to section 217, or to any wages which may be deemed under that section by virtue of active military service. Section 217(a)(1) provides, as here pertinent, that wages may be deemed "[for] purposes of determining entitlement to and the amount of any *monthly* benefit for any month after August 1950. . . ." (Emphasis supplied.) Thus, by referring only to monthly benefits, section 217 would appear to preclude the use of "deemed" wages for purposes of the insured status requirement of Medicare-Chronic Renal Disease.

While section 217 could arguably be construed in this restrictive manner, a contrary interpretation would be just as reasonable. The only manner in which

"deemed" wages might possibly affect an individual's entitlement to monthly benefits would be by enabling him to receive additional quarters of coverage and to attain an insured status, which is, of course, an eligibility requirement for monthly benefits. It is quite likely, therefore, that Congress in drafting section 217, was not intending to limit the use of deemed wages, e.g., by precluding their application here, so much as to designate in general terms *how* such wages might be applied. Indeed, until the enactment of section 226(e) in October 1972 insured status determinations were only necessary for determining entitlement to monthly benefits and to a disability freeze under section 216(i).

Further, there is no indication in the language or legislative history of section 226(e) that Congress intended to create a different test for Medicare insured status determinations than for cash benefits insured status determination. In devising the eligibility requirements for Medicare-Chronic Renal Disease, Congress depended heavily on basic title II entitlement concepts and in almost every case left those concepts unchanged. Accordingly, on the basis of the foregoing, the language in section 217, "for purposes of entitlement to monthly benefits," may reasonably be viewed as providing deemed wages generally for purposes of title II insured status determinations, including those required by section 226(e) and the wage earner's World War II military service wage credits may be used to establish entitlement to hospital insurance under this section.

An additional issue is raised by the wage earner's meeting fully insured status through the use of military service credits. If, after entitlement to hospital insurance is established, it is determined that a benefit based on World War II military service is payable to the wage earner by an agency or instrumentality of the United States, does section 217(a) (1) (B) require a redetermination of insured status, and, possibly, as a consequence, the termination of Medicare-Chronic Renal Disease coverage?

It appears that clause (B) of Section 217(a) (1) was drafted to prevent an individual from receiving two Federal periodic cash benefits on the basis of the same World War II military service. Such clause specifically limits its own applicability to cases involving a monthly benefit or a lump-sum death benefit. Thus, even though an individual is entitled to a benefit from another U.S. agency or instrumentality, he may still be deemed to have wages for purposes of the insured status requirement for a period of disability under section 216(i) (3). See the last sentence of clause (B).

Furthermore, if clause (B) were interpreted to require a determination for purposes of continuing Medicare eligibility, the effect for the beneficiary would likely be far more severe than the mere substitution of one cash benefit for another. The Medicare coverage might be terminated in the midst of a course of dialysis or in the postoperative stages of a renal transplant. In section 226(f), Congress prescribed that Medicare-Chronic Renal Disease would terminate only with the occurrence of events which are directly related to an individual's need for treatment for chronic renal disease. If an individual (once entitled) fails to meet eligibility requirements in section 226(e) which are not related to that condition, he nevertheless may continue to be eligible for Medicare coverage. The application of provisions of section 217(a) (1) (B) for Medicare purposes would be a substantial digression from what appears to be the Congressional intent. Accordingly, the recomputation of an individual's insured status for purposes of determining whether he may continue to be

eligible for Medicare on the base of chronic renal disease would not be required by section 217(a) (1) (B) of the Act.

(X—refer to SSR 75-9).

SECTION 1878(f), (42 U.S.C. 1395oo(f))—HOSPITAL INSURANCE—SECRETARY'S AUTHORITY TO REMAND CASES TO PROVIDER REIMBURSEMENT REVIEW BOARD

Gulf Coast Home Health Services, Inc., v. *Califano, U.S.D.C.*, District of Columbia, No. 77–1507—(10–10–78)

HCFAR–79–17c

42 CFR 405.1875

"The Secretary's authority to reverse, affirm, or modify a decision of the Provider Reimbursement Review Board contains no impediment to remanding a case to the Board."

SIRICA, District Judge:

This is an action for judicial review of a final decision of the Secretary of Health, Education, and Welfare denying certain items of cost reimbursement to a provider of home health services under the Medicare program. *See* 42 U.S.C. § 1395oo(f) (Supp. V 1975). The statute expressly makes this Court's review subject to the applicable provisions of the Administrative Procedure Act, therefore providing a substantial evidence type review. Both parties have moved for summary judgment. The government has requested that, in the alternative, the action be remanded to the agency.

Briefly, the plaintiff—Gulf Coast Health Services, Inc.—is a provider of home health services within the meaning of the Medicare provisions of the Social Security Act. After certain of its requests for cost reimbursement were denied by a fiscal intermediary, Gulf Coast appealed to the Provider Reimbursement Review Board (hereinafter "the Board"). The Board eventually modified the intermediary's determination, ruling substantially in favor of Gulf Coast. The Administrator of the Health Care Financing Administration, as statutory* designee of the Secretary of H.E.W., then reviewed the Board decision on his own motion pursuant to 42 U.S.C. § 1395oo(f)(1) (Supp. V 1975). The Administrator found that the Board decision was not supported by substantial evidence and reversed the award of cost reimbursement to Gulf Coast. The instant action followed.

The final agency decision hinged on the Administrator's determination that testimony and documentary evidence offered by Gulf Coast Homes'

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* "By administrative action the Secretary had delegated his authority to review decisions of the Provider Reimbursement Review Board to the Administrator of the Health Care Financing Administration.—Ed."

* Rulings based upon cases decided in the Federal courts upon appeal from the decision of the Secretary, HEW, are identified throughout the publication by a suffix "C" after the ruling number.

two principal executives would be afforded "no weight" in his review of the record. The two executives had been convicted of perjury—in connection with a Medicare related grand jury investigation—shortly before the Board rendered its decision. The Administrator formally admitted the convictions into evidence and made them a part of the record. Noting that the only substantial evidence in the record which supported the Board decision derived from evidence presented by the perjurers, the Administrator stated that this evidence would be disregarded and concluded that the Board decision therefore was unsupported by substantial evidence. Significantly, the Administrator also stated:

> The Administrator concludes that the Board's decision must be reversed; but that it would have been preferable to remand the case to the Board for its further consideration and action. Present law, however, does not give the Secretary the power to remand cases to the Board. The only options mentioned by Section 1879(f)(1) of the Act, as amended, [42 USCA 1395oo(f)] are "reversal, affirmance, or modification." If remand authority existed, it would have been helpful to have been able to ask the Board to consider obtaining additional evidence such as independent audits, independent expert testimony, official visits to the Provider, or such other evidence as the Board might find appropriate, in order to support the decision with substantial evidence.

Administrator's Decision of May 6, 1977,* at 13.

The Administrator's decision to accord the testimony of the convicted perjurers no weight was, of course, not compelled by the modern rules of evidence. Under the Federal Rules of Evidence, for example, a perjury conviction, while admissible for impeachment purposes, would not render a perjurer's testimony wholly incompetent. *See* Fed. R. Evid. 601 & 608. The trier of fact would generally be entitled to disregard the impeached testimony, but here that testimony was accorded "no weight" by a reviewing official who was not present during the taking of evidence.

This is not to say that the Administrator was not entitled to reexamine the factual findings of the Board, even with regard to credibility issues. *See generally* 5 U.S.C. § 557(b)(1976). It does mean that in the peculiar circumstances of this case—where significant new evidence relating to the credibility of the major provider witnesses was made a part of the record *after* the decision by the body which heard all the evidence and where the Administrator's own decision acknowledges that additional factfinding proceedings might well develop substantial evidence to support the original cost reimbursement award—a remand to the Board would have been the more judicious course of action. And although the Administrator felt that a remand was not within his power under a statute which instructs him to reverse, affirm, or modify the initial decision, *see* 42 U.S.C. § 1395oo(f)(1) (Supp. V 1975), the Court can find no such impediment in the language or spirit of the review provision.

Reviewing bodies are generally considered to have inherent powers to remand to the initial decision maker, and administrative reviewers should not be deemed to lack such power, absent an explicit statutory bar. As the Supreme Court has observed in a related context: "It is familiar appellate

* "Correct date of Administrator's Decision is July 1, 1977—Ed."

practice to remand cases for further proceedings without deciding the merits, where justice demands that course in order that some defect in the records may be supplied. Such a remand may be made to permit further evidence to be taken or additional findings to be made upon essential points." *Ford Motor Co. v. NLRB*, 304 U.S. 364, 373(1939). And as summarized by the District of Columbia Circuit, a court may remand to an agency "even prior to decision, and even assuming the agency was without fault, if 'the state of the record may preclude a just result.' " *Greater Boston Television Corp. v. FCC*, 463 F. 2d 268, 283–84 (D.C. Cir. 1971), *quoting Fleming v. FCC, 225 F. 2d 523, 526 (D.C. Cir. 1955).* It appears that an administrative remand in this case could have served a purpose identical to that contemplated by these statements of traditional judicial remand authority and purpose. As the Administrator himself implicitly acknowledged, this is a case where there were defects in the record and where the state of that record may have precluded a just result. For these same reasons, the Court will now do what the Administrator believed he was unable to do.

The Administrator's decision will be vacated; the action will be dismissed and remanded to the Administrator with instructions to remand to the Board for further proceedings consistent with this Memorandum.

SECTION 1978(f)—HOSPITAL INSURANCE—SECRETARY'S AUTHORITY TO REMAND CASES TO PROVIDER REIMBURSEMENT REVIEW BOARD—60 DAYS FOR SECRETARY'S REVIEW TO BEGIN WITH DATE OF NOTIFICATION OF BOARD'S DECISION AFTER REMAND

HCFAR 79–18

The Health Care Financing Administration adopts the court's position in the case of *Gulf Coast Home Health Services, Inc. v. Califano* [1] that the Secretary's authority to reverse, affirm or modify a decision of the Provider Reimbursement Review Board contains no impediment to remanding a case to the Board. The Administrator of the Health Care Financing Administration, as the Secretary's delegate, *will henceforth remand* appropriate cases to the Board. A decision of the Board after remand shall be final unless the Administrator, on his own motion, and within 60 days after the provider of services is notified of the Board's decision after remand, reverses, affirms, or modifies that decision.

POLICY STATEMENT:

Section 1878 of the Social Security Act (42 U.S.C. 1395oo) provides that any provider of services which has filed a required cost report for reimbursement for services under the Medicare program may obtain a hearing with respect to such cost report by the Provider Reimbursement

[1] (See HCFAR 79-17c , page 40).

Review Board (PRRB) if certain jurisdictional requirements are met.

Section 1878(f)(1) (42 U.S.C. 1395oo(f)(1)) states that a decision of the PRRB shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. The Secretary has delegated this authority to the Administrator of the Health Care Financing Administration.

While the statute does not specify that the authority of the Secretary to reverse, affirm, or modify a decision of the Board also empowers him to remand decisions to the Board for further action, the United States District Court for the District of Columbia in the case of *Gulf Coast Home Health Services, Inc., v. Califano* (Civil Action No. 77–1507) has held that the Administrator, acting on behalf of the Secretary, has such remand authority.

The Health Care Financing Administration has adopted the position of the court that the Administrator's authority to reverse, affirm, or modify a Board decision contains no impediment to the inherent power of the Administrator to remand such cases to the Board for further action consistent with the statute and regulations.

After remand, the Board will render a new decision which shall be final unless the Administrator, on his own motion, and within 60 days after the provider of services is notified of the Board's decision after remand, reverses, affirms, or modifies that decision.

SECTIONS 1842(b) (3) (B) (ii) and 1862(a).—REASONABLE CHARGE BASIS—ACCEPTANCE OF ASSIGNMENT BY SUPPLIER OF DURABLE MEDICAL EQUIPMENT

HCFAR 79-19

> Where a supplementary medical insurance enrollee has incurred expenses for a medically necessary appliance, ordering not the standard model but a more expensive one, and the supplier accepts assignment for payment pursuant to section 1842(b) (3) (B) (ii) of the Act, *held* acceptance of such assignment binds the supplier to the amount determined by the carrier to be the "reasonable charge" for equipment adequate to meet the enrollee's needs and he may not bill the enrollee for difference between that amount and the customary charge for the deluxe model sold.

Payment may be made on a reasonable charge basis under the provisions of Part B of title XVIII of the Social Security Act to, or on behalf of, a supplementary medical insurance enrollee under this part, for *medically necessary* durable medical equipment, including iron lungs, oxygen tents, hospital beds and wheelchairs used in the patient's home, (including an institution used as his home, other than a hospital or nursing home) whether furnished on a rental basis or purchased. Payment may *not,* however, be made under the program for any expenses incurred for items or services which are *not reasonable* and *necessary* for the diagnosis or treatment of illness or injury or to

improve the functioning of a malformed body member, nor for items or services which constitute personal comfort items or services. (Section 1862(a) (1) and (6))

Determinations as to the rates and amounts payable to suppliers of durable medical equipment are made by carriers under contract to the Secretary of the Department of Health, Education, and Welfare pursuant to the provisions of section 1842 of the Act. Subsection (b) thereof provides in pertinent part:

> (3) Each such contract shall provide that the carrier—
>
> * * * * * * *
>
> (B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policy holders and subscribers of the carrier, and such payment will * * * be made—
>
> (i) on the basis of an itemized bill; or
>
> (ii) on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service; * * *.

In effect, the SMI benefits (equal to 80 percent of the reasonable charge after the annual deductible has been met) are paid either to the enrollee who claims payment on the basis of an itemized bill, or to the supplier who has accepted an assignment under the terms of which he agrees that the reasonable charge will be his full charge. The supplier who accepts an assignment from the enrollee can legally claim and collect from the enrollee no more than the difference between the SMI benefit paid and the reasonable charge amount.

Situations have occurred where an enrollee, needing an item of durable medical equipment, has been furnished the necessary item by a supplier who accepts assignment. The model furnished is more elaborate than a standard model which is adequate for his needs (e.g., a wheelchair with special features which add to the comfort or appearance of the chair but are not necessary for efficient operation and serviceability). The carrier determines that the "reasonable charge" for that equipment is the price of the "standard" rather than the deluxe model, and the supplier then seeks to bill the patient for the difference between the "reasonable charge" determined by the carrier and the customary charge for the deluxe model furnished.

This has raised the question whether section 1842(b) (3) (B) (ii) of the Act quoted above binds a supplier of durable medical equipment who has accepted an assignment to accept the "reasonable charge" determined by the carrier as the *full* charge for the item sold, whether standard or deluxe.

Section 1842(b) (3) also provides that in determining what is the "reasonable charge" for medically required services or items, there shall be taken into consideration the customary charge for such services or items as well as the charge prevailing in the locality for similar services or items. The "reasonable charge," in the case of durable medical equipment (whether standard or deluxe), is the amount which can be allowed, under these criteria, for a piece of equipment that will adequately meet the patient's need. It is not necessarily the fair market value of the equipment furnished. As previously stated, acceptance of an assignment binds the supplier to accept the "reasonable charge" for covered services or items as the *full* charge. To permit the supplier of a deluxe piece of equipment to bill the enrollee for the customary charge differential between the standard appliance and the more

expensive appliance furnished would result in a dilution of the protection of enrollees which was intended by the assignment method.

Accordingly, where a SMI enrollee incurs expenses for a medically necessary appliance, and the supplier accepts assignment for payment, *held* such acceptance of an assignment binds the supplier to accept the "reasonable charge," as determined by the carrier, as his full charge for the item sold, whether standard or deluxe, under the provisions of section 1842(b) (3) (B) (ii).

It is true that the suppliers of durable medical equipment may not wish to accept assignment on deluxe items as a result of this rule. However, SMI enrollees will still be able to obtain more expensive items or equipment and program payment will be made if they are willing and able to pay the difference between the amount allowed and the supplier's charge. As amended by the Social Security Amendments of 1967, section 1842 of the Act permits payment of SMI benefits to enrollees on the basis of an itemized bill, whether or not such bill has been paid. In such cases, payment to the enrollee on the basis of an itemized bill would be in the same amount as the benefit which would be paid to the supplier who accepts assignment—80 percent of the "reasonable charge" for items or equipment necessary for treatment of the patient's conditions (subject, of course, to any applicable deductible).

(X—refer to SSR 69-9).

SECTION 1862(a)(11).—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS—EXCLUSION FROM HEALTH INSURANCE COVERAGE OF CHARGES IMPOSED BY IMMEDIATE RELATIVE

42 CFR 405.315 HCFAR 79-20

Where a physician furnished services to his stepmother, a Part B enrollee, after the death of his natural father, *held,* payment for such services is precluded by section 1862(a)(11) of the Act. The steprelationship did not terminate with the death of the physician's father, the person through whom the relationship was originally created.

Dr. S, a physician, submitted a claim for payment for services he furnished L, his widowed stepmother, a supplementary medical insurance enrollee under Part B of title XVIII of the Social Security Act. L married Dr. S' father 5 years before his death, well after Dr. S had reached adulthood. Dr. S had never assumed any financial responsibility for L either before or since his father's death, nor had they ever lived in the same household. The claim for payment submitted by Dr. S was denied under section 1862 (a)(11) of the Act, which excludes from coverage charges imposed by immediate relatives of the beneficiary or members of his household. Dr. S protested this determination on the basis that he does not consider L to be his immediate relative. He further contended that upon the death of his father any relationship that may have existed at one time was severed and therefore payment should be made for the services he had furnished.

At issue in the instant case is whether section 1862(a)(11) of the Social Security Act precludes payment to Dr. S for the services furnished L, his stepmother, following the death of his father.

Section 405.315 of Health Care Financing Administration Regulations (42

CFR 405.315) restates the statutory exclusion and in subsection (a) defines "an immediate relative" for purposes of section 1862(a)(11) of the Act, as follows:

> Any person who has any of the following degrees of relationship to any other person is an "immediate relative": (1) Husband and wife; (2) natural parent, child, and sibling; (3) adopted child and adoptive parent; (4) *stepparent, stepchild,* stepbrother, and stepsister * * *. (Emphasis supplied.)

Thus, the specific issue in this case is whether the steprelationship was terminated upon the death of Dr. S' father.

The marriage of Dr. S' father to L, the beneficiary, created a relationship between the two parties and their blood kin known as "affinity." The relationship by affinity, which is created only by marriage, is analogous in terms of its legal consequences to the relationship of consanguinity or relationship by blood. Just as consanguinity is not destroyed by death, neither is the relationship by affinity.[1]

Further, the lack of parent-child relationship in a home setting between the stepparent and the stepchild has not been held to limit the affinity relationship and legal consequences arising therefrom. For example, the Court of Civil Appeals of Texas interpreting a State workmen's compensation statute (Section 8a, Article 8306 Revised Civil Statutes, 1925) awarded a stepmother the entire benefit although she had not been dependent on the deceased stepson nor had he been a member of her household for several years following his natural father's death. *Security Union Casualty Company* v. *Kelly,* 229 SW 286 (1927).

With respect to the facts in the instant case, the cited judicial precedents lend persuasive support for the consclusion that an affinity relationship between individuals does not end with the death of the person through whom the relationship was established.

Accordingly, it is *held,* L, the beneficiary, is an "immediate relative" of Dr. S under section 405.315 of Health Care Financing Administration Regulations cited above, and therefore services furnished to her by her physician stepson are excepted from coverage under the provisions of section 1862(a)(11) of the Social Security Act.

(X—refer to SSR 69-66)

SECTION 1862(a)(3).—HEALTH INSURANCE BENEFITS—EXCLUSION OF CHARGES FOR PREPAID AMBULANCE SERVICE CONTRACTED FOR BY CITY FOR ITS RESIDENTS

42 CFR 405.231 (j), 405.312 HCFAR 79-21

> Where an ambulance service company and a governmental entity (city) enter into contract under which the company is engaged to provide all necessary ambulance services to the residents of the governmental entity without charge to the individual residents in return for payment by the governmental entity of a fixed annual sum for such services, *held,* ambulance services provided to residents of the entity by the company under contract are excluded from coverage under the Medicare program in accordance with section 1862(a)(3) of the Social Security Act.

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[1] For the leading court decisions to this effect, see *Spear* v. *Robinson,* 29 Me. 531 (May term 1849), *Simcoke* v. *Grand Lodge A.O.U.W.,* 51 N W 8, Iowa (1892), *McGaughey* v. *Grand Lodge A.O.U.W. of the State of Minnesota,* 180 N W 1001 Minn., (1921).

Early in 1965, an ambulance service company contracted with a governmental entity, a city, to provide ambulance services for *all* residents of the city without charge to them. The city, in turn, made substantial annual payments as provided in the contract to the company for furnishing these services. The terms of the contract (and the billing practices of the ambulance company) demonstrated the mutual understanding of the parties that no charges would be made to individual patients residing in the city, and no such charges were ever assessed prior to enactment of title XVIII of the Social Security Act, providing health insurance benefits for persons age 65 and over. After enactment, a number of supplementary medical insurance enrollees under title XVIII were assessed charges by the ambulance service company for ambulance services furnished them. The enrollees, at the company's request, assigned their claims to the ambulance company for payment under Part B, and the company, in turn, has filed a claim as assignee, to receive payment for the ambulance services furnished.

Payment may be made under Part B of title XVIII of the Social Security Act to, or on behalf of, a supplementary medical insurance enrollee under this part for medical and other health services, including ambulance service, where the use of other methods of transportation is contraindicated by the individual's condition. The payments so provided are subject to certain exclusions and limitations contained in the Act. One such exclusion, contained in section 1862 of the Act provides that:

> (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B or any expenses incurred for items or services—
>
> * * * * * * *
>
> (3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity) * * *.

In view of the fact that, under the contract between the ambulance service company and the city, the ambulance services provided by the company were paid for directly by the city, a governmental entity, section 1862(a)(3) of the Act precludes payment for such services.

Accordingly, it is *held* that the ambulance services provided to the residents of the city by the ambulance service company under contract with such city are excluded from coverage under the Medicare program in accordance with section 1862(a)(3) of the Social Security Act.

(X—refer to SSR 70-8)

SECTION 1862(a)(11).—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS—EXCLUSION FROM HEALTH INSURANCE COVERAGE OF CHARGES IMPOSED BY IMMEDIATE RELATIVES

42 CFR 405.315 HCFAR 79-22

A physician furnished medical services to a beneficiary entitled to supplementary medical insurance benefits. The beneficiary was the husband of the physician's wife's sister. *Held,* payment to the physician is not precluded by section 1862(a)(11) of the Act, since the physician is not an immediate relative of the beneficiary as that term is defined in the regulations (42 CFR 405.315). The relationship of brother-in-law does not exist between the physician and the beneficiary. Under the regulation, the physician is considered to be brother-in-law to his wife's sister, but not to the sister's spouse.

Section 1862(a) of the Social Security Act provides, in pertinent part, that:

(a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

* * * * * * *

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household; * * * *

In implementing this provision, section 405.315 of Health Care Financing Administration Regulations (42 CFR 405.315) further provides, in pertinent part, as follows:

Payment on a reasonable charge basis may not be made under Part B of title XVIII of the Act * * * for expenses incurred by an individual, if such expenses constitute charges * * * imposed by physicians or other persons who are immediate relatives of such individual or members of his household, to the extent that such charges exceed the actual costs incurred by such physicians or other persons in procuring items furnished such individual.

(a) Any person who has any of the following degrees of relationship to any other person is an "immediate relative": * * * (5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; * * * *

* * * * * * *

(c) The exclusion refers to the person imposing the charges, who might not be the person rendering the services. For example, where the charges are imposed by a:

(1) Physician or other practitioner, the exclusion would apply to charges imposed for personal services if the physician or other practitioner has the excluded relationship to the beneficiary * * *.

In the instant case the physician furnished medical services to the husband of his wife's sister. The patient was a beneficiary entitled to supplementary medical insurance benefits. Thus the question raised, whether or not the physician may receive payment for his services under title XVIII of the Act, depends on whether the physician is an immediate relative of the beneficiary within the meaning of section 1862(a)(11) of the Act. This in turn depends on whether the relationship of brother-in-law existed between the physician and the beneficiary.

Black's Law Dictionary, 4th Edition, 1951, p. 81, defines "brother-in-law" as: "A wife's brother or a sister's husband * * *. Two men are not brothers-in-law from the circumstances merely of having married sisters."

The courts have repeatedly held, as to the relationship existing between the husbands of two sisters (or the wives of two brothers), that they were not brothers-in-law (or sisters-in-law) to each other. This view has been adhered to in denying the right to take exception to judges because of interest, *Farmers*

Loan & Trust Co. v. *Iowa Water Co.*, 80 F. 467, Iowa 1897; the right to challenge grand jurors, *Cruce* v. *State*, 87 Fla. 406 (1924), 100 So. 264; and in denying recognition as a beneficiary for life insurance, *National Life & Accident Insurance Co.* v. *Middlebrooks*, 27 Ala. App. 247 (1939), 170 So. 84; et al.

In the light of the foregoing, it is clear that the relationship of brother-in-law did not exist between the physician and the beneficiary. Accordingly, it is *held* that payment for services furnished by the physician to the husband of his wife's sister is not excluded under section 1862(a)(11) of the Act.

(X—refer to SSR 71-10)

SECTION 1862(b).—SUPPLEMENTARY MEDICAL INSURANCE—EXCLUSION OF PAYMENTS FOR SERVICES UNDER A WORKMEN'S COMPENSATION LAW OR PLAN—NO WORKMEN'S COMPENSATION PAYMENT MADE OR REASONABLY EXPECTED TO BE MADE

HCFAR 79-23

A supplementary medical insurance beneficiary sustains a work-related injury and incurs expense for medical services from a source not approved by the employer's workmen's compensation carrier. He is denied payment for these expenses by the workmen's compensation carrier pursuant to State statute permitting the individual the perrogative of seeking medical attention of his choice at his own expense. *Held*, payment of supplementary medical insurance benefits is not precluded by the "workmen's compensation exclusion" in section 1862(b) of the Social Security Act, since no payment has been made and none can reasonably be expected to be made for such services under the State's workmen's compensation statute.

G, a supplementary medical insurance beneficiary under title XVIII of the Social Security Act, injured his arm in a work accident. He was treated by a physician selected by his employer and the bills were paid by the employer's workmen's compensation carrier, the Y Insurance Company. Subsequently, G visited the X Clinic for a "final evaluation" of the permanent injury to his arm. The Y Insurance Co. denied payment of the bill for this visit totaling $69 because the clinic was not authorized by the insurance company to treat workmen's compensation beneficiaries. G has filed a claim for reimbursement of this expense under part B of title XVIII of the Social Security Act.

The benefits provided an individual by the health insurance program under title XVIII of the Act consist of entitlement to have payment made on his behalf for hospital and medical services, subject to certain exclusions and limitations contained in the Act. One such exclusion, contained in section 1862(b) of the Act, provides that:

> Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State. . . .

This issue to be determined in this case is whether section 1862(b), *supra*, precludes reimbursement for the $69 expense incurred by G for the services furnished him by the X Clinic.

The Y Insurance Company has taken the position that if G had gone to the company's doctors for his final evaluation, they would have considered

paying his bills. Their denial of his claim was based on section 138.8 of chapter 48 of the Illinois workmen's compensation statute, which provides that an employee who suffers a work-related injury "*may secure his own physician,* surgeon, and hospital services *at his own expense.*" (Emphasis supplied.)

This section of the Illinois statute places responsibility on the employer to provide first aid and necessary medical, surgical, and hospital services required to adequately care for the employee's medical condition arising from his employment. This responsibility appears to be absolute, and if the employer does not provide the services, the employee may recover the expenses he incurs in obtaining reasonably necessary medical attention.[1] However, where the employee secures such services directly, without the employer's authorization, he has no right to reimbursement under workmen's compensation for such expenses.

Since no payment has been made and none can reasonably be expected to be made under the workmen's compensation plan for these services furnished G by the X Clinic, Medicare benefits should be made available as appropriate[2] and on the same basis as they would be available where any service or item is excluded from workmen's compensation coverage because of limitations within that program. This view is in accord with the purpose of the exclusion in section 1862(b) of the Act which, it appears, was enacted to prevent a duplication of payments. To the extent that there is a duplication of payments under the health insurance and workmen's compensation programs, there might be a tendency for the States to neglect improving the latter to the detriment of industrial safety and the welfare of individual workers.[3]

However, in the instant case there is no possibility of a duplication of title XVIII and workmen's compensation benefits. The Illinois workmen's compensation plan specifically limits its liability to services by physicians selected and approved by the employer. Thus, in accordance with the provisions of this particular system, since G secured medical attention through a clinic not authorized by the employer's workmen's compensation carrier, his claim was denied. Therefore, any benefits payable on this claim under title XVIII will not be duplicated by payment under a workmen's compensation plan. Also, it would not seem reasonable for this program, by a denial of benefits, to urge claimants to use only those physicians chosen by their employer or his workmen's compensation carrier in order to obtain third party payment when the workmen's compensation statute itself gives them the express authority to look elsewhere for professional services.

Nor is a case such as this similar to instances in which workmen's compensation coverage is available but not pursued by the claimant. In such instances Medicare benefits must be barred because a beneficiary must first exhaust his benefit rights under workmen's compensation before payment can be made under title XVIII. Failure to take proper and timely action under such circumstances will preclude payment under title XVIII to the extent that payment could have been made under workmen's compensation if such action had been taken.

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[1] See *Jewel Tea Co., Inc.,* v. *Industrial Commission,* 39 Ill. 2d 180, 238 N.E. 2d 557 (1968).

[2] i.e., subject to carrier determination of the reasonableness of the charge and to any applicable deductible or coinsurance.

[3] See Senate Finance Committee Hearings (1965), pp. 147–8, 892–900, 949–54; also, Senate Report No. 404, 89th Cong. 1st Session, p. 49 and House Report No. 213, 89th Cong., 1st Session, p. 42, cited in HCFAR 79-6, p. 105.

Here, however, the workmen's compensation plan *itself* has limited its liability so as to preclude payment of claims such as this. As the workmen's compensation system has given the claimant, as one of his benefit rights, the authority to go outside the system for medical care at his own expense, we can insist on no greater effort in the direction of obtaining the benefits under that program as a condition to the payment of benefits under this one, where the intent of this program's offset provision is to guard against encroaching on the States' domain.

Since no payment has been made and none can be expected to be made under the workmen's compensation system for the services furnished G by the X Clinic, it is, accordingly, *held* that payment may be made under title XVIII subject to the reasonableness of the charge and applicable deductibles and coinsurance.

(X—refer to SSR 71-29)

SECTION 1835(d).—SUPPLEMENTARY MEDICAL INSURANCE—SERVICES FURNISHED BY FACILITY OPERATED BY A FEDERAL AGENCY

HCFAR 79-24

A housing project, operated by the Federal Housing Authority (FHA) following foreclosure, contracted with a physician for X dollars per month to furnish medical services for the project's residents. The residents are charged a fee which is collected by the physician on behalf of the FHA. *Held,* the project is not a Federal provider of services or other Federal agency within the meaning of section 1835(d) of the Social Security Act and accordingly, payment for medical and other covered services furnished by the project to Medicare beneficiaries is not precluded.

A housing project, containing a medical clinic, was acquired by the Federal Housing Authority (FHA) following foreclosure of the mortgage. The clinic is staffed by a full-time physician who is assisted by a nurse and other employees. The physician and other staff members work under a contract with the FHA for fixed salaries. The FHA charges patients for the services they receive. They are collected by the physician on behalf of the FHA. He is required to remit all such fees to the project manager.

The issue raised is whether FHA ownership of the housing project makes the project a "Federal agency" for purposes of prohibiting Medicare payment for the physician services under the terms of section 1835(d) of the Social Security Act. This section of the Act provides in pertinent part:

> No payment may be made under this part of any Federal provider of services or other Federal agency, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; . . . .

The purpose of the FHA in operating and maintaining a medical facility which it acquires following a mortgage default, is to conserve the assets pending sale of the property rather than to provide federally sponsored medical care. Federal ownership under such circumstances does not endow the project with the attributes of a "Federal agency" as contemplated by section 1835(d). Accordingly, payment for medical and other covered services furnished by the project to Medicare beneficiaries is not precluded.

(X—refer to SSR 72-10)

SECTION 1836(2)(B) (42 U.S.C. 1395o(2)(B))—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS—ELIGIBILITY—ALIEN RESIDENCY REQUIREMENT

42CFR 405.205 HCFAR [79-25c]

Mathews v. *Diaz, et al,* 96 S.Ct. 1883 (1976).

Under section 1836(2) of the Social Security Act, a person not entitled to hospital insurance benefits under Part A of Title XVIII is eligible to enroll for supplementary medical insurance benefits (SMI) under Part B of Title XVIII, if he is a citizen or, if he is an alien, only if he has been lawfully admitted for permanent residence and has resided in the U.S. continuously during the 5 years immediately preceding the month in which he applies for enrollment. *Held,* Congress has no constitutional duty to provide all aliens with the welfare benefits provided to citizens; *Further Held,* the difference in the SMI eligibility requirements within the class of aliens does not deprive aliens with less than 5 years of U.S. residency of liberty or property in violation of the Due Process clause of the Fifth Amendment.*

STEVENS, Justice:

The question presented by the Secretary's appeal is whether Congress may condition an alien's eligibility for participation in a federal medical insurance program on continuous residence in the United States for a five-year period and admission for permanent residence. The District Court held that the first condition was unconstitutional and that it could not be severed from the second. Since we conclude that both conditions are constitutional, we reverse.

Each of the appellees is a resident alien who was lawfully admitted to the United States less than five years ago. Appellees Diaz and Clara are Cuban refugees who remain in this country at the discretion of the Attorney General; appellee Espinosa has been admitted for permanent residence. All three are over 65 years old and have been denied enrollment in the Medicare Part B supplemental medical insurance program established by § 1831 *et seq.* of the Social Security Act of 1935, 49 Stat. 620, as added, 79 Stat. 301, and as amended, 42 U.S.C. § 1395j *et seq.* (1970 ed. and Supp. IV).[1] They brought this action to challenge the statutory basis for that denial. Specifically, they attack 42 U.S.C. § 1395o(2), which grants eligibility to resident citizens who are 65 or older but denies eligibility to such aliens unless they have been admitted for permanent residence and also have resided in the United States

* Any individual age 65 or over is entitled to hospital insurance benefits if he is entitled to monthly benefits under section 202 of the Act or the Railroad Retirement Act (RRA). A disabled individual under age 65 who has been receiving disability benefits under title II or the RRA for 25 consecutive months or who has chronic renal disease and meets certain insured status requirements is also entitled to hospital insurance benefits. Aliens entitled to hospital insurance benefits under any of these provisions need not meet any residency requirements to be eligible to enroll for SMI.

[1] The Medicare Part B medical insurance program for the aged covers a part of the cost of certain physicians' services, home health care, outpatient physical therapy, and other medical and health care. 42 U.S.C. § 1395k (1972 ed. and Supp. IV). The program supplements the Medicare Part A hospital insurance plan, § 1811 *et seq.* of the Social Security Act of 1935, 49 Stat. 620, as added, 79 Stat. 291, and as amended, 42 U.S.C. § 1395c *et seq.* (1970 ed. and Supp. IV), and it is financed in equal parts by the United States and by monthly premiums paid by individuals aged 65 or older who choose to enroll. 42 U.S.C. § 1395r(b) (1972 ed. and Supp. IV).

for at least five years.[2] Appellees Diaz and Clara meet neither requirement; appellee Espinosa meets only the first.

On August 18, 1972, Diaz filed a class action complaint in the United States District Court for the Southern District of Florida alleging that his application for enrollment had been denied on the ground that he was not a citizen and had neither been admitted for permanent residence nor resided in the United States for the immediately preceding five years. He further alleged that numerous other persons had been denied enrollment in the Medicare Part B program for the same reasons. He sought relief on behalf of a class of persons who have been or will be denied enrollment in the Medicare insurance program for failure to meet the requirements of 42 U.S.C. § 1395o(2). Since the complaint prayed for a declaration that § 1395o(2) was unconstitutional and for an injunction requiring the Secretary to approve all applicants who had been denied eligibility solely for failure to comply with its requirements, a three-judge court was constituted.

On September 28, 1972, the District Court granted leave to add Clara and Espinosa as plaintiffs and to file an amended complaint. That pleading alleged that Clara had been denied enrollment for the same reasons as Diaz, but explained that Espinosa, although a permanent resident since 1971, had not attempted to enroll because he could not meet the durational residence requirement, and therefore any attempt would have been futile. The amended complaint sought relief on behalf of a subclass represented by Espinosa—that is, aliens admitted for permanent residence who have been or will be denied enrollment for failure to meet the five-year continuous residence requirement—as well as relief on behalf of the class represented by Diaz and Clara.[3]

On October 24, 1972, the Government moved to dismiss the complaint on the ground, among others, that the District Court lacked jurisdiction over the subject matter because none of the plaintiffs had exhausted his administrative

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[2] Title 42 U.S.C. § 1395o (1972 ed., Supp. IV) provides:

"Every individual who—(1) is entitled to hospital insurance benefits under Part A, or (2) has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part, is eligible to enroll in the insurance program established by this part."

This case does not raise any issues involving subsection (1).

[3] The District Court certified a class and a subclass, defined, respectively, as follows: "All immigrants residing in the United States who have attained the age of 65 and who have been or will be denied enrollment in the supplemental medical insurance program under Medicare, 42 U.S.C. § 1395j *et seq.* (1970), because they are not aliens lawfully admitted for permanent residence who have resided in the United States continuously during the five years immediately preceding the month in which they apply for enrollment as required by [42 U.S.C. § 1395o(2)(B) (1970 ed., Supp. IV)].

* * * * * * *

"All immigrants lawfully admitted for permanent residence in the United States who have attained the age of 65 and who have been or will be denied enrollment in the supplemental medical insurance program under Medicare, 42 U.S.C. § 1395j et seq. (1970), solely because of their failure to meet the five-year continuous residency requirement of [42 U.S.C. § 1395o(2)(B) (1970 ed., Supp. IV)]." *Diaz* v. *Weinberger,* 361 F. Supp., 1, 7 (SD Fla. 1973) (footnote omitted).

These class certifications are erroneous. The District Court did not possess jurisdiction over the claims of the members of the plaintiff class and subclass who "will be denied" enrollment. Those who "will be denied" enrollment, as the quoted phrase is used in the certification, are those who have yet to be denied enrollment by formal administrative decision. See 361 F. Supp., at 6–7 & n. 7. But the complaint does not allege, and the record does not show, that the Secretary has taken any action with respect to such persons that is tantamount to a denial. It follows that the District Court lacked jurisdiction over their claims, see *post,* at 8–9; *Weinberger* v. *Salfi,* 422 U.S. 749, 764, and that the class and subclass are too broadly defined. In view of our holding that the statute is constitutional, we need not decide whether a narrower class and subclass could have been properly certified.

remedies under the Social Security Act. Two days later on October 26, 1972, Espinosa filed his application for enrollment with the Secretary. He promptly brought this fact to the attention of the District Court, without formally supplementing the pleadings.

None of the appellees completely exhausted available avenues for administrative review. Nevertheless, the Secretary acknowledged that the applications of Diaz and Clara raised no disputed issues of fact and therefore the interlocutory denials of their applications should be treated as final for the purpose of this litigation. This satisfied the jurisdictional requirements of 42 U.S.C. § 405(g). *Weinberger* v. *Salfi*, 422 U.S. 749, 763–767; *Weinberger* v. *Wiesenfeld*, 420 U.S. 636, 641 n. 8. The Secretary did not make an equally unambiguous concession with respect to Espinosa, but in colloquy with the court he acknowledged that Espinosa had filed an application which could not be allowed under the statute.[4] The District Court overruled the Government's motion to dismiss and decided the merits on crossmotions for summary judgment.

The District Court held that the five-year residence requirements violated the Due Process Clause of the Fifth Amendment[5] and that since it could not be severed from the requirement of admission for permanent residence, the alien eligibility provisions of § 1395o(2) (B) were entirely unenforceable. *Diaz* v. *Weinberger*, 361 F. Supp. 1 (S.D. Fla. 1973). The District Court reasoned that "even though fourteenth amendment notions of equal protection are not entirely congruent with fifth amendment concepts of due process," *id.*, at 9, the danger of unjustified discrimination against aliens in the enactment of welfare programs is so great, in view of their complete lack of representation in the political process, that this federal statute should be tested under the same pledge of equal protection as a state statute. So tested, the court concluded that the statute was invalid because it was not both rationally based and free from invidious discrimination. It rejected the desire to preserve the fiscal integrity of the program, or to treat some aliens as less deserving than others, as adequate justification for the statute. Accordingly, the court enjoined the Secretary from refusing to enroll members of the class and subclass represented by appellees.

The Secretary appealed directly to this Court.[6] We noted probable jurisdiction. 416 U.S. 980. After hearing argument last Term, we set the case for reargument. 420 U.S. 959. We now consider (1) whether the District Court had jurisidction over Expinosa's claim; (2) whether Congress may discriminate in favor of citizens and against aliens in providing welfare benefits; and (3) if so, whether the specific discriminatory provisions in § 1395o(2) (B) are constitutional.

I

Espinosa's claim squarely raises the question whether the requirement of five years continuous residence is constitutional, a question that is not necessarily presented by the claims of Diaz and Clara. For if the requirement of admission for permanent residence is valid, their applications were properly

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[4] See *post*, at 8–9 and n. 11.

[5] "[N]or shall any person . . . be deprived of life, liberty, or property, without due process of law. . . ." U.S. Const., Amend. V.

[6] The Secretary asserted jurisdiction in this Court by direct appeal under 28 U.S.C. §§ 1252, 1253. Since we possess jurisdiction under § 1252, which provides for direct appeal to this Court from a judgment of a federal court holding a federal statute unconstitutional in a civil action to which a federal officer is a party, we need not decide whether an appeal lies under § 1253. *Weinberger* v. *Salfi*, 422 U.S. 749, 763 n. 8.

denied even if the durational residence requirement is defective.[7] We must therefore decide whether the District Court had jurisdiction over Espinosa's claim.

We have little difficulty with Espinosa's failure to file an application with the Secretary until after he was joined in the action. Although 42 U.S.C. § 405(g) establishes filing of an application as a nonwaivable condition of jurisdiction, *Mathews* v. *Eldridge*, No. 74-204, Slip op., at 6-7 (Feb. 24, 1976); *Weinberger* v. *Salfi*, 422 U.S. 749, 764, Espinosa satisfied this condition while the case was pending in the District Court. A supplemental complaint in the District Court would have eliminated this jurisdictional issue,[8] since the record discloses, both by affidavit and stipulation, that the jurisdictional condition was satisfied, it is not too late, even now, to supplement the complaint to allege this fact.[9] Under these circumstances, we treat the leadings as properly supplemented by the Secretary's stipulation that Espinosa had filed an application.

A further problem is presented by the absence of any formal administrative action by the Secretary denying Espinosa's application. Section 405(g) requires a final decision by the Secretary after a hearing as a prerequisite of jurisdiction. *Mathews* v. *Eldridge*, *supra*, Slip op., at 6-8; *Weinberger* v. *Salfi*, *supra*, at 763-765. However, we held in *Salfi* that the Secretary could waive the exhaustion requirements which this provision contemplates and that he had done so in that case. *Id.*, at 765-767; accord, *Matthews* v. *Eldridge*, *supra*, Slip op., at 6-8 (dictum); *Weinberger* v. *Wiesenfeld*, 420 U.S. 636, 641 n. 8. We reach a similar conclusion here.

The plaintiffs in *Salfi* alleged that their claims had been denied by the local and regional Social Security offices and that the only question was one of constitutional law, beyond the competence of the Secretary to decide. These allegations did not satisfy the exhaustion requirements of § 405(g) of the Secretary's regulations, but the Secretary failed to challenge the sufficiency of the allegations on this ground. We interpreted this failure as a determination by the Secretary that exhaustion would have been futile and deferred to his judgment that the only issue presented was the constitutionality of a provision of the Social Security Act.

The same reasoning applies to the present case. Although the Secretary moved to dismiss for failure to exhaust administrative remedies, at the hearing on the motion he stipulated that no facts were in dispute, that the case was ripe for dispostion by summary judgment, and that the only issue before the District

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[7] Diaz and Clara contend that requirement of lawful admission for permanent residence should be construed so that it is satisfied by aliens, such as themselves, who have been paroled into the United States at the discretion of the Attorney General. However, such aliens remain in the United States at the discretion of the Attorney General, 8 U.S.C. § 1182(d)(5), and hence cannot have been "lawfully admitted for permanent residence," as § 1395o(2)(B) requires.

[8] Fed Rule Civ. Proc. 15(d); *Security Ins. Co. of New Haven* v. *United States ex rel. Haydis*, 338 F.2d 444, 447–449 (CA9 1964).

[9] "Defective allegations of jurisdiction may be amended, upon terms, in the trial or appellate courts." 28 U.S.C. § 1653. Although the defect in Espinosa's allegations must be cured by supplemental pleading, instead of amended pleading, the statutory purpose of avoiding needless sacrifice to defective pleading applies equally to this case. See *Schlesinger* v. *Councilman*, 420 U.S. 738, 744 n. 9; *Willingham* v. *Morgan*, 395 U.S. 402, 407–408 and n. 3. Despite Espinosa's failure to supplement the complaint, the District Court was aware that he had filed his application; since the Secretary stipulated that the application had been filed, the defect in the pleadings surely did not prejudice him.

Court was the constitutionality of the statute.[10] As in *Salfi*, this constitutional question is beyond the Secretary's competence. Indeed, the Secretary has twice stated in this Court that he stipulated in the District Court that Espinosa's application would be denied for failure to meet the durational residence requirement.[11] For jurisdictional purposes, we treat the stipulation in the District Court as tantamount to a decision denying the application and as a waiver of the exhaustion requirements. Cf. *Weinberger* v. *Wiesenfeld, supra,* at 640 n. 6, 641 n. 8.

We conclude, as we did in *Salfi*, that the Secretary's submission of the question for decision on the merits by the District Court satisfied the statutory requirement of a hearing and final decison. We hold that Espinosa's claim, as well as the claims of Diaz and Clara, must be decided.

II

There are literally millions of aliens within the jurisdiction of the United States. The Fifth Amendment, as well as the Fourteenth Amendment, protects every one of these persons from deprivation of life, liberty or property without due process of law. *Wong Yang Sung* v. *McGrath,* 339 U.S. 33, 48-51; *Wong Wing* v. *United States,* 163 U.S. 228, 238; see *Russian Volunteer Fleet* v. *United States,* 282 U.S. 481, 489. Even one whose presence in this country is unlawful, involuntary, or transitory, is entitled to that constitutional protection. *Wong Yang Sung, supra: Wong Wing, supra.*

The fact that all persons, aliens and citizens alike, are protected by the Due Process Clause does not lead to the further conclusion that all aliens are entitled to enjoy all the advantages of citizenship or, indeed, to the conclusion that all aliens must be placed in a single homogenous legal classification. For a host of constitutional and statutory provisions rest on the premise that a legitimate distinction between citizens and aliens may justify attributes and benefits for one class not accorded to the other;[12] and the class of aliens is itself a heterogenous multitude of persons with a wide-ranging variety of ties to this

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[10] Record on Appeal, at 224–227. See Memorandum of Law in Support of Defendant's Motion for Summary Judgment and in Opposition to Plaintiffs' Motion for Summary Judgment, Record on Appeal, at 259–260.

[11] Jurisdictional Statement, at 3 n. 3; Brief for the Appellant, at 5 n. 5. In his Supplemental Brief, filed after our decision in *Salfi*, the Secretary argues that the District Court did not possess jurisdiction over Espinosa's claim because it was not until after the District Court had issued its injunction that the Secretary resolved an unspecified factual issue presented by Espinosa's application, and that such a belated confirmation that Espinosa's application should be denied could not confer jurisdiction upon the District Court *nunc pro tunc*. Supplemental Brief for the Appellant, at 4 and n. 1. However, the District Court's jurisdiction was not founded upon the Secretary's subsequent confirmation that Espinosa's application should be denied, but rather upon the Secretary's stipulation in the District Court that no factual issues remained, that the case was ripe for disposition by summary judgment, and that the only issue was the constitutionality of the statute. Even though *Salfi* had not been decided when he so stipulated, he is not now free to withdraw his stipulation, and no reason appears why he should be permitted to do so.

[12] The Constitution protects the privileges and immunities only of citizens, Amend. XIV, § 1; see Art. IV, § 2, cl. 1, and the right to vote only of citizens. Amends. XV, XIX, XXIV, XXVI. It requires that Representatives have been citizens for seven years, Art. I, § 2, cl. 2, and Senators citizens for nine, Art. I, § 3, cl. 3, and that the President be a "natural born Citizen." Art II, § 1, cl. 5.

A multitude of federal statutes distinguish between citizens and aliens. The whole of Title 8 of the United States Code, regulating aliens and nationality, is founded on the legitimacy of distinguishing citizens and aliens. A variety of other federal statutes provide for disparate treatment of aliens and citizens. These include prohibitions and restrictions upon government employment of aliens, *e. g.,* 10 U.S.C. § 5571; 22 U.S.C. § 1044 (e), upon private employment of aliens, *e. g.,* 10 U.S.C. § 2279; 12 U.S.C. § 72, and upon investments and businesses of aliens, *e. g.,* 12 U.S.C. § 619; 47 U.S.C. § 17;

country.[13]

In the exercise of its broad power over naturalization and immigration, Congress regularly makes rules that would be unacceptable if applied to citizens. The exclusion of aliens[14] and the reservation of the power to deport[15] have no permissible counterpart in the Federal Government's power to regulate the conduct of its own citizenry.[16] The fact that an act of Congress treats aliens differently from citizens does not in itself imply that such disparate treatment is "invidious."

In particular, the fact that Congress has provided some welfare benefits for citizens does not require it to provide life benefits for *all aliens*. Neither the overnight visitor, the unfriendly agent of a hostile foreign power, the resident diplomat, nor the illegal entrant, can advance even a colorable constitutional claim to a share in the bounty that a conscientious sovereign makes available to its own citizens and *some* of its guests. The decision to share that bounty with our guests may take into account the character of the relationship between the alien and this country: Congress may decide that as the alien's tie grows stronger, so does the strength of his claim to an equal share of that munificence.

Footnote 12 continued from page 56.

statutes excluding aliens from benefits available to citizens; *e. g.,* 26 U.S.C. § 931 (1970 ed. and Supp. IV); 46 U.S.C. § 1171(a), and from protections extended to citizens, *e. g.,* 19 U.S.C. § 1526; 29 U.S.C. § 633a (1970 ed., Supp. IV); and statutes imposing added burdens upon aliens, *e. g.,* 26 U.S.C. § 6851(d); 28 U.S.C. § 1391(d). Several statutes treat certain aliens more favorably than citizens. *E. g.,* 19 U.S.C. § 1586(e); 50 U.S.C. App. § 453 (1970 ed., Supp. IV). Other statutes, similar to the one at issue in this case, provide for equal treatment of citizens and aliens lawfully admitted for permanent residence. 10 U.S.C. § 8253; 18 U.S.C. § 613(2) (1970 ed., Supp. IV). Still others equate citizens and aliens who have declared their intention to become citizens. *E. g.,* 43 U.S.C. § 161; 30 U.S.C. § 22. Yet others condition equal treatment of an alien upon reciprocal treatment of United States citizens by the alien's own country. *E. g.,* 10 U.S.C. § 7435(a); 28 U.S.C. § 2502.

[13] The classifications among aliens established by the Immigration and Nationality Act, 66 Stat. 163, as amended, 8 U.S.C. § 1101 *et seq.* (1970 ed. and Supp. IV), illustrate the diversity of aliens and their ties to this country. Aliens may be immigrants or nonimmigrants. 8 U.S.C. § 1101(a)(15). Immigrants, in turn, are divided into those who are subject to numerical limitations upon admissions and those who are not. The former are subdivided into preference classifications which include: grown unmarried children of citizens; spouses and grown unmarried children of aliens lawfully admitted for permanent residence; professionals and those with exceptional ability in the sciences or arts; grown married children of citizens; brothers and sisters of citizens; persons who perform specified permanent skilled or unskilled labor for which a labor shortage exists; and certain victims of persecution and catastrophic natural calamities who were granted conditional entry and remained in the United States at least two years. 8 U.S.C. § 1153(a)(1)–(7). Immigrants not subject to numerical limitations include: children and spouses of citizens and parents of citizens at least 21 years old; natives of independent countries of the Western Hemisphere; aliens lawfully admitted for permanent residence returning from temporary visits abroad; certain former citizens who may reapply for acquisition of citizenship; certain ministers of religion; and certain employees or former employees of the United States Government abroad. 8 U.S.C. §§ 1101(a)(27), 1151(a), (b). Nonimmigrants include: officials and employees of foreign governments and certain international organizations; aliens visiting temporarily for business or pleasure; aliens in transit through this country; alien crewmen serving on a vessel or aircraft; aliens entering pursuant to a treaty of commerce and navigation to carry on trade or an enterprise in which they have invested; aliens entering to study in this country; certain aliens coming temporarily to perform services or labor or to serve as trainees; alien representatives of the foreign press or other information media; certain aliens coming temporarily to participate in a program in their field of study or specialization; aliens engaged to be married to citizens; and certain alien employees entering temporarily to continue to render services to the same employers. 8 U.S.C. § 1101(a)(15). In addition to lawfully admitted aliens, there are, of course, aliens who have entered illegally.

[14] *Kleindienst* v. *Mandel,* 408 U.S. 758, 765–770.

[15] *Galvan* v. *Press,* 347 U.S. 522, 530–532; *Harisiades* v. *Shaughnessy,* 342 U.S. 580, 584–591.

[16] See *Uemel* v. *Rusk,* 381 U.S. 1, 13–16, *Aptheker* v. *Secretary of State,* 378 U.S. 500, 505–514; *Kent* v. *Dulles,* 357 U.S. 116, 125–130.

The real question presented by this case is not whether discrimination between citizens and aliens is permissible; rather, it is whether the statutory discrimination *within* the class of aliens—allowing benefits to some aliens but not to others—is permissible. We turn to that question.

III

For reasons long recognized as valid, the responsibility for regulating the relationship between the United States and our alien visitors has been committed to the political branches of the Federal Government.[17] Since decisions in these matters may implicate our relations with foreign powers, and since a wide variety of classifications must be defined in the light of changing political and economic circumstances, such decisions are frequently of a character more appropriate to either the legislature or the executive than to the judiciary. This very case illustrates the need for flexibility in policy choices rather than the rigidity often characteristic of constitutional adjudication. Appellees Diaz and Clara are but two of over 440,000 Cuban refugees who arrived in the United States between 1961 and 1972.[18] And the Cuban parolees are but one of several categories of aliens who have been admitted in order to make a humane response to a natural catastrophe or an international political situation.[19] Any rule of constitutional law that would inhibit the flexibility of the political branches of government to respond to changing world conditions should be adopted only with the greatest caution.[20] The reasons that preclude judicial review of political questions[21] also dictate a narrow standard of review of decisions made by the Congress or the President in the area of immigration and naturalization.

Since it is obvious that Congress has no constitutional duty to provide *all aliens* with the welfare benefits provided to citizens, the party challenging the constitutionality of the particular line Congress has drawn has the burden of advancing principal reasoning that will at once invalidate that line and yet tolerate a different line separating some aliens from others. In this case the appellees have challenged two requirements, first that the alien be admitted as a permanent resident, and second that his residence be of a duration of at least five years. But if these requirements were eliminated, surely Congress would at

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[17] "[A]ny policy toward aliens is vitally and intricately interwoven with contemporaneous policies in regard to the conduct of foreign relations, the war power, and the maintenance of a republican form of government. Such matters are so exclusively entrusted to the political branches of government as to be largely immune from judicial inquiry or interference." *Harisiades* v. *Shaughnessy,* 342 U.S. 580, 588–589 (footnote omitted). Accord, *e. g., Kleindienst* v. *Mandel,* 408 U.S. 753, 765–767; *Fong Yue Ting* v. *United States,* 149 U.S. 698, 711–713.

[18] Cuban Refugee Program, Weekly Statistical Report for November 13–17, 1972, Joint Appendix, at 40.

[19] See 8 U.S.C. §§ 1153(a)(7), 1182(d)(5).

[20] An unlikely, but nevertheless possible consequence of holding that appellees are constitutionally entitled to welfare benefits would be a further extension of similar benefits to over 440,000 Cuban parolees.

[21] "It is apparent that severol formulations which vary slightly according to the settings in which the questions arise may describe a political question, although each has one or more elements which identify it as essentially a function of the separation of powers. Prominent on the surface of any case held to involve a political question is found a textually demonstrable constitutional commitment of the issue to a coordinate political department; or a lack of judicially discoverable and manageable standards for resolving it; or the impossibility of deciding without an initial policy determination of a kind clearly for nonjudicial discretion; or the impossibility of a court's undertaking independent resolution without expressing lack of the respect due coordinate branches of government; or an unusual need for unquestioning adherence to a political decision already made; or the potentiality of embarrassment from multifarious pronouncements by various departments on one question." *Baker* v. *Carr,* 369 U.S. 186, 217.

least require that the alien's entry be lawful; even then, unless mere transients are to be held constitutionally entitled to benefits, *some* durational requirement would certainly be appropriate. In short, it is unquestionably reasonable for Congress to make an alien's eligibility depend on both the character and the duration of his residence. Since neither requirement is wholly irrational, this case essentially involves nothing more than a claim that it would have been more reasonable for Congress to select somewhat different requirements of the same kind.

We may assume that the five-year line drawn by Congress is longer than necessary to protect the fiscal integrity of the program.[22] We may also assume that unnecessary hardship is incurred by persons just short of qualifying. But it remains true that some line is essential, that any line must produce some harsh and apparently arbitrary consequences, and, of greatest importance, that those who qualify under the test Congress has chosen may reasonably be presumed to have a greater affinity to the United States than those who do not. In short, citizens and those who are most like citizens qualify. Those who are less like citizens do not.

The task of classifying persons for medical benefits, like the task of drawing lines for federal tax purposes, inevitably requires that some persons who have an almost equally strong claim to favored treatment be placed on different sides of the line; the differences between the eligible and the ineligible are differences in degree rather than differences in the character of their respective claims. When this kind of policy choice must be made, we are especially reluctant to question the exercise of congressional judgment.[23] In this case, since appellees have not identified a principled basis for prescribing a different standard than the one selected by Congress, they have, in effect, merely invited us to substitute our judgment for that of Congress in deciding which aliens shall be eligible to participate in the supplementary insurance program on the same conditions as citizens. We decline the invitation.

IV

The cases on which appellees rely are consistent with our conclusion that this statutory classification does not deprive them of liberty or property without due process of law.

Graham v. *Richardson,* 403 U.S. 365, provides the strongest support for appellees' position. That case holds that state statutes that deny welfare benefits to resident aliens, or to aliens not meeting a requirement of durational residence within the United States, violate the Equal Protection Clause of the Fourteenth Amendment and encroach upon the exclusive federal power over the entrance and residence of aliens. Of course, the latter ground of decision actually supports our holding today that it is the business of the political branches of the Federal Government, rather than that of either the States or the

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[22] The District Court held that the durational residence requirement was not rationally related to maintaining the fiscal integrity of the Medicare Part B program because the program is financed on a "current cost" basis, half by appropriations from the general revenues and half by premiums from enrolled individuals; because aliens who do not meet the residence requirement would constitute no greater burden on the general revenues than enrolled citizens who have not paid federal taxes or who pay their premiums from federally subsidized welfare benefits; because aliens, like citizens, must pay federal taxes; and because the residency requirement only postpones treatment of aliens until costlier medical care is necessary. 361 F. Supp., 10–12.

[23] *Weinberger* v. *Salfi,* 422 U.S. 749, 768–774; *Dandridge* v. *Williams,* 397 U.S. 471, 483–487.

Federal judiciary, to regulate the conditions of entry and residence of aliens. The equal protection analysis also involves significantly different considerations because it concerns the relationship between aliens and the States rather than between aliens and the Federal Government.

Insofar as state welfare policy is concerned,[24] there is little, if any, basis for treating persons who are citizens of another State differently from persons who are citizens of another country. Both groups are noncitizens as far as the State's interest in administering its welfare programs are concerned. Thus, a division by a State of the category of persons who are not citizens of that State into subcategories of United States citizens and aliens has no apparent justification, whereas, a comparable classification by the Federal Government is a routine and normally legitimate part of its business. Furthermore, whereas the Constitution inhibits every State's power to restrict travel across its own borders, Congress is explicitly empowered to exercise that type of control over travel across the borders of the United States.[25]

The distinction between the constitutional limits on state power and the constitutional grant of power to the Federal Government also explains why appellees' reliance on *Memorial Hospital* v. *Maricopa County,* 415 U.S. 250, is misplaced. That case involved Arizona's requirement of durational residence within a county in order to receive nonemergency medical care at the county's expense. No question of alienage was involved. Since the sole basis for the classification between residents impinged on the constitutionally guaranteed right to travel within the United States, the holding in *Shapiro* v. *Thompson,* 394 U.S. 618, required that it be justified by a compelling state interest.[26] Finding no such justification, we held that the requirement violated the Equal Protection Clause. This case, however, involves no state impairment of the right to travel—nor indeed any impairment whatever of the right to travel within the United States; the predicate for the equal protection analysis in those cases is simply not present. Contrary to appellees' characterization, it is

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[24] We have left open the question whether a State may prohibit aliens from holding elective or important nonelective positions or whether a State may, in some circumstances, consider the alien status of an applicant or employee in making an individualized employment decision. See *Sugarman* v. *Dougall,* 413 U.S. 634, 646–649. *In re Griffith,* 413 U.S. 717, 728–729 and n. 21.

[25] "State alien residency requirements that either deny welfare benefits to noncitizens or condition them on longtime residency, equate with the assertion of a right, inconsistent with federal policy, to deny entrance and abode. Since such laws encroach upon exclusive federal power, they are constitutionally impermissible." *Graham* v. *Richardson, supra,* at 380.

[26] In *Shapiro* v. *Thompson,* we held that state-imposed requirements of durational residence within the State for receipt of welfare benefits denied equal protection because such requirements unconstitutionally burdened the right to travel interstate. Since the requirements applied to aliens and citizens alike, we did not decide whether the right to travel interstate was conferred only upon citizens. However, our holding was predicated expressly on the requirement "that all citizens be free to travel throughout the length and breadth of our land uninhibited by statutes, rules, or regulations which unreasonably burden or restrict this movement." Id., at 629. See *Graham* v. *Richardson, supra,* at 375–376, 377–380.

Appellees also gain no support from *Washington* v. *Legrant,* 304 U.S. 618, a case decided with *Shapiro* v. *Thompson. Legrant* involved a congressionally imposed requirement of one year's residence within the District of Columbia for receipt of welfare benefits. As in *Shapiro* v. *Thompson,* no question of alienage was involved. We held that the requirement violated the Due Process Clause of the Fifth Amendman for the same reasons that the state-imposed durational residence requirements violated the Equal Protection Clause of the Fourteenth Amendment. *Id.,* at 641–642. Unlike the situation in *Shapiro* and *Legrant,* the durational residence requirement in this case could at most deter only the travel of aliens into the United States. The power of Congress to prevent the travel of aliens into this country cannot seriously be questioned.

not "political hypocrisy" to recognize that the Fourteenth Amendment's limits on state powers are substantially different from the constitutional provisions applicable to the federal power over immigration and naturalization.

Finally, we reject the suggestion that *United States Dept. of Agriculture* v. *Moreno*, 413 U.S. 528, lends relevant support to appellees' claim. No question involving alienage was presented in that case. Rather, we found that the denial of food stamps to households containing unrelated members was not only unsupported by any rational basis but actually was intended to discriminate against certain politically unpopular groups. This case involves no impairment of the freedom of association of either citizens or aliens.

We hold that § 13950(2) (B) has not deprived appellees of liberty or property without due process of law.

The judgment of the District Court is *Reversed.*

(X-refer to SSR 76-40c)

SECTION 1837(b) (2).—SUPPLEMENTARY MEDICAL INSURANCE—CLAIMANT MAY NOT ENROLL MORE THAN TWICE

HCFAR 79-26

Held, a claim for enrollment in the supplementary medical insurance program under part B of title XVIII of the Social Security Act, filed by an individual after termination of his two previous enrollments, must be denied under section 1837(b) of the Act, which precludes an individual from enrolling in the supplementary medical insurance program more than twice.

H filed an application for enrollment in the supplementary medical insurance program under Part B of title XVIII of the Social Security Act on April 8, 1969. His application was denied under section 1837(b) of the Social Security Act because he enrolled for supplementary medical insurance on two previous occasions and was awarded periods of coverage, which were terminated both times due to nonpayment of premiums. H has protested this decision on the basis that he now needs supplementary medical insurance coverage, and it is inequitable to deny him enrollment since he did not understand the premium payment requirements or the limitations on reenrollment when he enrolled previously in the program.

Section 1837(b) of the Social Security Act, with respect to enrollment for supplementary insurance, provides, as pertinent here, that: "No individual may enroll under this part more than twice."

The issue to be resolved in this case is whether or not H may enroll for supplementary medical insurance coverage for a third time.

The evidence of record shows that H filed an application for enrollment in the supplementary medical insurance program in March 1966 and that his entitlement to such insurance coverage was terminated effective December 31, 1966, for nonpayment of premiums. He enrolled a second time during a general enrollment period in 1968. The evidence shows clearly that at least two notices of premiums due were mailed to H in connection with his second period of coverage. H states that he has no recollection of having received the second notice warning him of the approaching deadline for payment. He explains that his health and memory are impaired, and that he needs medical insurance. In any event, H did not pay the premiums owed; but in a letter dated August 8,

1968, he requested that the premiums due be deducted from what he believed to be wrongfully withheld special age 72 benefits. (Since H was receiving nonservice connected Veterans Administration benefits, the special age 72 benefits were not payable.)[1] His second period of coverage was terminated effective December 31, 1968, again for nonpayment of premiums. In March 1969 H attempted to enroll for the third time.

Although it is quite likely that H was not aware of the consequences of his mistaken insistence that his medical insurance premiums be deducted from the benefits to which he thought he was entitled, section 1837(b) of the Social Security Act is very specific in precluding an individual's enrollment in supplementary medical insurance more than twice.[2] The legislative history shows that this restriction on reenrollment was deliberately imposed by Congress in order to reduce the possibility of people enrolling or reenrolling when their health deteriorates, thus increasing the costs of medical insurance. A person might otherwise choose to have coverage only during periods of poor health, without paying premiums during periods of good health.

Accordingly, it is *held,* H's application for enrollment in the supplementary medical insurance program under part B of title XVIII of the Social Security Act, dated April 8, 1969, is denied since he already had two previous enrollment periods that were terminated.

(X-refer to SSR 71-40)

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[1] For discussion of the effect of nonservice connected V.A. benefits on special age 72 benefits, see SSR 68–36, C.B. 1968, p. 44.

[2] There are exceptions to this rule which are not applicable here. One exception is for indigent aged individuals who have been enrolled (and had their premiums paid) by a State under a "buy-in agreement" with the Secretary pursuant to section 1843 of the act. As provided in section 1843(e), upon termination of such an individual's buy-in coverage (e.g., because he is no longer indigent), he has individual coverage for which he must pay premiums, and for all purposes of medical insurance is treated as if he had enrolled in his initial enrollment period. He may then terminate his coverage and re-enroll once regardless of any prior enrollments.

Exceptions can also be made applying the equitable relief amendment (section 1837 (h)) when government fault, error, delay, or inaction resulted in termination of SMI.

SECTION 1837(h) (42 U.S.C. 1395p)—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS—INITIAL ENROLLMENT PERIOD—WAIVER OF ENROLLMENT PERIOD REQUIREMENTS

42 CFR Part 405.226 HCFAR 79-27

Where individual under age 65, upon filing application for monthly insurance benefits under title II of Social Security Act, was informed by the Social Security Administration representative that application for enrollment in Supplementary Medical Insurance program would be mailed as soon as she became eligible to enroll, but through inadvertence or error the Social Security Administration failed to mail the enrollment form timely, *held,* claimant deemed to have filed a timely enrollment request in the first month of the initial enrollment period, pursuant to section 1837(h)* of Social Security Act, added by Social Security Amendments of 1972, P.L. 92-603.

W, born June 2, 1906, filed application for retirement insurance benefis in December 1970. She elected to receive reduced benefits effective January 1971, prior to her attainment of age 65. Since W filed her application for retirement benefits in December 1970, more than 3 months prior to age 65, she was not then eligible to enroll in the SMI program. In September 1971 she filed application for enrollment in the Supplementary Medical Insurance program (SMI) under part B of title XVIII, Social Security Act, and was advised that her enrollment began in December 1971. W protested this determination and insisted that the effective date of her enrollment should be June 1971, the month she attained age 65 and became entitled to hospital insurance, and the first month for which she could have by timely enrollment become entitled to SMI. W based this contention on assurances given by the Administration's representative at the time she filed her application for monthly benefits that the Social Security Administration would mail to her an enrollment form as soon as she became eligible to enroll, and that she would qualify for SMI beginning June 1971 upon prompt completion and return of the form. The form was not received by W until September 1971, and was then promptly executed and returned to the Social Security Administration. Meanwhile, she had undergone surgery in July 1971, and incurred medical expenses which would not be covered on the basis of a coverage period beginning after July 1971.

The general issue in this case is whether the claimant's SMI coverage may be found to have commenced prior to December 1, 1971. The specific issue is whether the claimant filed or may be deemed to have filed a timely application for enrollment in the Supplementary Medical Insurance program which would permit an effective coverage date prior to December 1, 1971.

Section 1836 of the Social Security Act, as amended, provides, as pertinent here, that an individual may enroll for Supplementary Medical Insurance if he has attained age 65 and is entitled to hospital insurance benefits.

Section 1837 of the Act, as pertinent here, provides that a request for enrollment in the Supplementary Medical Insurance program will be effective only if filed within certain enrollment periods specified in that section.

* Section 1837(h) provides:
In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part or Part A pursuant to section 1818 is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government, or its instrumentalities, the Secretary may take such action (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction. (Ed.)

Subsection (d) provides in effect that for an individual otherwise eligible (as in W's case) the initial enrollment period is a seven month period beginning three months before the month he attains 65 and ending three months after such month.

Section 1838 of the Act, as pertinent here, sets forth coverage periods which may be established for those who have properly enrolled in the Supplementary Medical Insurance program. This section provides that for individuals who enroll during the first three months of their initial enrollment period, the coverage period shall begin with the month of attainment of age 65. For those who enroll in the month they attain age 65, the coverage period begins with the following month. For those enrolling in the month after the month of attainment of age 65, the coverage period begins for the second month following the month of enrollment. For those individuals who enroll in the second or third month following the month of attainment of age 65, the coverage period begins with the third month following the month of enrollment.

Section 1837(h) of the Social Security Act was added to section 1837 by section 259(a) of the Social Security Amendments of 1972 (P.L. 92-603), enacted on October 30, 1972. Section 1837(h) is retroactive to July 1, 1966, and provides that in any case where the Secretary finds that an individual's enrollment or nonenrollment in the Supplementary Medical Insurance program is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee or agent of the Federal Government or its instrumentalities, the Secretary may take such action (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof, and with appropriate adjustment of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

It appears from the facts set forth above that due to some delay or error, the Social Security Administration failed to mail the enrollee timely the enrollment card as she had been told would be done. It cannot reasonably be expected that W or her husband would be familiar with the technical requirements of enrollment during certain enrollment periods and with the provisions concerning the effective dates of coverage periods based on enrollment dates. She did enroll in September 1971 promptly upon receiving the enrollment form.

The present situation is illustrative of the hardships and inequities intended to be corrected by the provisions of section 1837(h) of the Act. W's failure to enroll during the three month period preceding June 1971 was, in the words of section 1837(h) "unintentional, inadvertent, or erroneous" and it is clear that it was the result of the error or inaction of an officer or employee of the Federal Government. This provision of the Social Security Amendments of 1972, became effective as of July 1, 1966, and is applicadle to this case.

Under section 1837(f) and (g) of the Act (enacted into law as section 206 of the Social Security Amendments of 1972), effective for persons who became entitled to hospital insurance after June 1973, such a problem would not arise today: An individual is deemed to have enrolled for SMI in the first 3 months of his initial enrollment period if he files an application in or prior to such first 3 months which establishes his entitlement to hospital insurance. Since section 1837(h) may be applied retroactively to the inception of the program in July 1966, it enables the Social Security Administration to provide relief for cases

which arose before the "automatic enrollment" provisions of section 1837(f) and (g) became effective.

Accordingly, it is *held* that W's application for enrollment in the Supplementary Medical Insurance program is deemed to have been filed during the three month period preceding her attainment of age 65 in June 1971, with a coverage period effective June 1, 1971.

(X-refer to SSR 75-1)

PART II, CUMULATIVE LISTINGS OF SELECTED COURT DECISIONS PUBLISHED AS RULINGS

Gulf Coast Home Health Services, Inc. v. Califano
(hospital insurance benefits, Secretary's authority to remand cases to Provider Reimbursement Review Board), 79-18c (p40)

Mathews v. Diaz, et al (supplementary medical insurance—eligibility) 79-25c (P.52)

Part III, Cumulative Numeric Index of Decisions of the Administrator, HCFA, on PRRB decisions (April-November 1978)

78-D6—Reasonable Salary; related organizations (4/7/78)

78-D7—Joint educational activities (4/7/78)

78-D9—Lower of reasonable costs or customary charges; depreciation costs; reclassification of transporters' costs to routine care (5/5/78)

78-D10—Related organizations; reasonableness of rental payments; allocation of nursing administration costs (5/5/78)

78-D13—Deductible, coinsurance and noncovered service debts; proration of partial payments from Medicare beneficiaries (5/8/78)

78-D14—Joint educational activities (5/10/78)

78-D19—Joint educational activities; liability insurance (5/9/78)

78-D26—Related organizations; reasonable rental costs (6/20/78)

78-D28—Patient telephone and television costs; purchase of stock v. purchase of assets; depreciation; use of accelerated depreciation; return on equity capital (6/14/78)

78-D33—Leasing of hospital operating department to physicians (7/17/78)

78-D43—Offset of interest income derived from trusteed funds against interest expense (8/15/78)

78-D45—Allocation of sales prices—appraisals—seller; Recapture of accelerated depreciation (8/18/78)

78-D46—Investment income; Allocation of sales prices—appraisals—buyer (8/18/78)

78-D47—Administrative, supervisory, and clerical costs (8/14/78)

78-D49—Lower of reasonable costs or customary charges (8/31/78)

78-D55—Interest expense; related organizations (9/26/78)

78–D57—Interest expense; offset of income earned against interest expense; capitalization v. expensing of interest; cost related to coffee shops (9/28/78)

78–D60—Telephone and television costs; purchase of stock v. purchase of assets; return on equity capital; interest costs (9/28/78)

78–D62—Joint educational costs (9/22/78)

78–D61—Interest expense; offset of gains against interest expense (10/8/78)

78–D64—Cost of educational activities; joint educational costs (10/24/78)

78–D65—Costs related to patient care; Tel Med; telephone costs (10/27/78)

Part IV, Quarterly Listing of Published Health Care Financing Administration Program Regulations (April-November 1978)

The following amendments and additions to HFCA regulations have been published in the *Federal Register:*

1. Notice—Statewide Professional Standards Review Council of Connecticut—Request for Nominations for Public Member Positions on the Council (April 4, 1978—43 FR 14126)
2. Notice—Statewide Professional Standards Review Council of Maryland—Request for Nominations for Public Member Positions on the Council (April 4, 1978—43 FR 14126)
3. Notice—Statewide Professional Standards Review Council of Massachusetts—Request for Nominations for Public Member Positions on the Council (April 4, 1978—43 FR 14127)
4. Notice—Statewide Professional Standards Review Council of New York—Request for Nominations for Public Member Positions on the Council (April 4, 1978—43 FR 14127)
5. 42 CFR Part 449—Federal Financial Participation in State Claims for Abortions (May 2, 1978—43 FR 18679)
6. Notice—Statewide Professional Standards Review Council of Illinois—Request for Nominations for Public Member Positions on the Council (May 4, 1978—43 FR 19292)
7. Notice—Statewide Professional Standards Review Council of Indiana—Request for Nominations for Public Member Positions on the Council (May 4, 1978—43 FR 19292)
8. Notice—Statewide Professional Standards Review Council of North Carolina—Request for Nominations for Public Member Positions on the Council (June 2, 1978—43 FR 24142)
9. Notice—Statewide Professional Standards Review Council of Florida—Request for Nominations for Public Member Positions on the Council (June 2, 1978—43 FR 24142)

10. Notice—Withdrawl—42 CFR Parts 405, 450—Administration of Medical Assistance Programs and Federal Health Insurance for the Aged and Disabled—Utilization Review (June 7, 1978—43 FR 24715)

11. Notice—New Directions for Skilled Nursing and Intermediate Care Facilities—Notice of Public Meetings (June 8, 1978—43 FR 24873)

12. Notice—Extension of Grace Period for Recently Reclassified Hospitals (June 15, 1978—43 FR 25873)

13. Notice—Economic Index for Physician's Services for the Period July 1978 through June 1979 (June 30, 1978—43 FR 28559)

14. 42 CFR Parts 405 & 450—Rural Health Clinic Services (July 14, 1978—43 FR 30520)

15. 42 CFR Part 449—Federal Financial Participation in State Claims for Abortions (July 21, 1978—43 FR 31868)

16. 42 CFR Part 450—State Medicaid Fraud Control Units (July 24, 1978—43 FR 32078)

17. 42 CFR Parts 405 & 450—Lowest Charge Level for Medical Services, Supplies and Equipment (July 26, 1978—43 FR 32294)

18. Notice—List of Specific Items and Services Subject to Lowest Charge Level (July 26, 1978—43 FR 32335)

19. 42 CFR Part 405—Conditions for Coverage of Suppliers of End Stage Renal Disease (ESRD) Services (August 11, 1978—43 FR 35698)

20. Notice—Statement of Organization, Functions, and Delegations of Authority (September 1, 1978—43 FR 39177)

21. Notice—Screening Guidelines and Payment Limit for Medicare and Medicaid Reimbursement (September 21, 1978—43 FR 42787)

22. Notice—Schedule of Limits on Hospital Costs for Cost Reporting Periods Beginning On or After October 1, 1978 (September 26, 1978—43 FR 43558)

23. 42 CFR Part 405 Entitlement to Medicare Benefits Based on End-Stage Renal Disease (September 28, 1978—43 FR 44802)

24. 42 CFR Part 448—Medicaid Eligibility: Technical Amendments (September 28, 1978—43 FR 44528)

25. Notice—Inpatient Hospital Deductible for 1979 (September 29, 1978—43 FR 44891)

26. 42 CFR Part 462—Designation of Alternate PSRO's (September 29, 1978—43 FR 44848)

27. 42 CFR Subchapter C—Medical Assistance Program—Medicaid Regulations—Reorganization and Rewriting (September 29, 1978—43 FR 45176)

28. Notice—Schedule of Guidelines for Physical Therapy Services (October 6, 1978—43 FR 46377)

29. Notice—Schedule of Guidelines for Respiratory Therapy Services (October 6, 1978—43 FR 46378)

30. 42 CFR Part 405—Coverage of Dialysis Supplies, Equipment, and Support Services (October 24, 1978—43 FR 49720)

31. Notice—Medicare and Medicaid Hospice Projects (October 27, 1978—43 FR 50376)

32. Notice—Medicare and Medicaid Contracting (November 1, 1978—43 FR 50970)

33. 42 CFR Part 441—Federal Financial Participation in State Claims for Sterilizations (November 8, 1978—43 FR 52171)

34. Notice—Privacy Act of 1974—System of Records—Program Integrity Case Files (November 13, 1978—43 FR 52524)

35. Notice—Medicare and Medicaid Contracting—Comment Period Extended (November 30, 1978—43 FR 56102)

36. Notice—Maximum Allowable Cost Limits for Certain Drugs; Extension of Comment Period (November 30, 1978—43 FR 56102)

Part V, Index of Administrative Staff Manuals and Instructions

The Freedom of Infomation Act, as amended (Public Law 93-502), requires each government agency to make available for public inspection and copying all administrative staff manuals and instructions to staff which affect any member of the public. In order to give the public an understanding of what material is thereby available, agencies must provide a regularly updated index of pertinent titles. This index itself, like the manuals and other materials it lists, is required by law to be available to the public for inspection and copying upon request.

The Index will be maintained in all Health Care Financing Administration Regional offices, where it may be examined by members of the public. The office will supply photocopies of selected pages upon request. (There may be a fee charged for this service, depending on the quantity of material requested.)

The listings which follow in this index represent an update of those instructions issued by the components of the Health Care Financing Administration through November 30, 1978.

Any questions regarding this index should be made in writing to:

Health Care Financing Administration
Medicare Bureau
Office of Program Policy
6401 Security Boulevard
Baltimore, Maryland 21235

MEDICAID

ACTION TRANSMITTALS

The Action Transmittals are designed to transmit policies of the Medicaid Bureau to individuals who participate in and administer the Medicaid program. A numeric listing follows of the Action Transmittals issued through November 30, 1978:

HCFA-AT-78-3	—	List of Fiscal Agents and Health Insuring Agencies
HCFA-AT-78-4	—	Adjustment of State Claims for FFP to Exclude Payments for Ineligible Medicaid Recipients, including Medicaid Recipients with Understated (Spend Down) Liability
HCFA-AT-78-5	—	PSRO Long-term Care Review: Relationship to the Medicaid Program Relief of Financial Penalties under Section 1903(g)(1) of the Social Security Act (Refer to SRS-AT-75-42 & SRS-AT-76-141)
HCFA-AT-78-6	—	State Medicaid Fraud Control Units
HCFA-AT-78-7	—	Title XIX, Social Security Act: Restrictions Applicable to Sterilization—Correction of NPRM
HCFA-AT-78-8	—	Affirmation of Continuing Reporting Requirement for Quarterly Statements of Financial Plan
HCFA-AT-78-9	—	Medicaid Quality Control Program
HCFA-AT-78-10	—	Federal Financial Participation in Claims for Abortions
HCFA-AT-78-11	—	Solicitations of Contributions from Medicaid Patients by Providers of Long-term Care Services
HCFA-AT-78-12	—	Title XIX, Social Security Act: State Medicaid Contracts
HCFA-AT-78-13	—	Title XIX, Social Security Act: Preprinted State Plan Amendments on (1) Assignment of Rights to Medical Care Support and Payments as a Condition of Eligibility, and (2) Cooperative Arrangements with other State Agencies for Enforcement of Rights to Support and Collection of Assigned Payments
HCFA-AT-78-14	—	Rural Health Clinics' Conditions for Certification
HCFA-AT-78-15	—	Title XIX, Social Security Act, Section 1903(g), Utilization Control (UC) Validation Survey for the Quarter Ending December 31, 1977
HCFA-AT-78-16	—	Title XIX, Social Security Act: Supplement D of the Handbook of Public Assistance Administration

HCFA-AT-78-17	—	Review Responsibility and Authority of Professional Standards Review Organizations (PSROs)
HCFA-AT-78-18	—	Medicare and Medical Assistance Programs; Designation of Section Numbers Correction of Agency Title and Cross-References
HCFA-AT-78-19	—	Supplemental Statement of Basis and Purpose of Regulations; Reimbursement on a Reasonable Cost Related Basis for Skilled Nursing and Intermediate Care Facility Services
HCFA-AT-78-20	—	Title XIX, Social Security Act; State Contracting Practices
HCFA-AT-78-21	—	Inpatient Psychiatric Services Under 21
HCFA-AT-78-22	—	Title XIX, Social Security Act: Preprinted State Plan Amendment on Contracts (Refer to HCFA-AT-78-12)
HCFA-AT-78-23	—	Title XIX, Social Security Act: Preprinted State Plan Amendment on Cooperation with Medicaid Fraud Control Units (Refer to HCFA-AT-78-6)
HCFA-AT-78-24	—	Title XIX, Social Security Act: Prohibition Against Reassignment of Claims
HCFA-AT-78-25	—	Title XIX, Social Security Act: Reasonable Cost Reimbursement of Inpatient Hospital Services
HCFA-AT-78-26	—	Title XIX, Social Security Act: Medicaid Claims Processing Systems: Explanation of Benefit Notices
HCFA-AT-78-27	—	Title XIX, Social Security Act: Medicaid Eligibility
HCFA-AT-78-28	—	Part 405—Federal Health Insurance for the Aged and Disabled—Coverage and Reimbursement of Rural Health Clinic Services
HCFA-AT-78-29	—	Reconsideration of Disallowances
HCFA-AT-78-30	—	Title XIX, Social Security Act: Preprinted State Plan Amendment on Prohibition Against Reassigment of Medicaid Provider Claims (Refer to HCFA-AT-78-24)
HCFA-AT-78-31	—	Approval of Medicaid Share of State Certification Agency Budgets and Supplemental Budgets, Budget Control Instructions and Claiming of Expenditures for State Certification Agency Activities Related to the Survey and Certification of Long-Term Care Facilities (Skilled Nursing Facilities—SNFs and Intermediate Care Facilities—ICFs)
HCFA-AT-78-32	—	Title XIX, Social Security Act: Rural Health Clinic Services Coverage and Reimbursement

HCFA-AT-78-33 — Applicability of Federal Matching Rates of 90% and 75% to MMIS Cost Other Than Salary, other Compensation, Fraud and Training

HCFA-AT-78-34 — Title XIX, Social Security Act: Medicaid Quality Control System

HCFA-AT-78-35 — MMB Medical Assistance Manual: Federal Financial Participation to States in Cost of Administration of Medicaid Management Information Systems: Guidelines for Sending Explanation of Benefit (EOB) Notices

HCFA-AT-78-36 — Title XIX, Social Security Act: Preprinted State Plan Amendment of Revised Eligibility Regulations (Refer to HCFA-AT-78-27)

HCFA-AT-78-37 — Title XIX, Social Security Act: Section 1903(g) Utilization Control (UC) Validation Survey for the Quarter Ending March 31, 1978, in the following ten States: Mass., N.Y., Penn., Tenn., Minn., Texas., Missouri, Colo., Hawaii, Oregon

HCFA-AT-78-38 — Title XIX, Social Security Act: Early and Periodic Screening, Diagnosis and Treatment Program Improvement Plan

HCFA-AT-78-39 — Title XIX, Social Security Act: Preprinted State Plan Amendment on Medicaid Quality Control System

HCFA-AT-78-40 — Title XIX, Social Security Act: Preprinted State Plan Amendment on Payments for Inpatient Hospital Services

HCFA-AT-78-41 — Title XIX, Social Security Act: Medicaid Quality Control Program

HCFA-AT-78-42 — Improper Claims for Medical Assistance Expenditures for Presumptively and Conditionally Eligible Persons in General and Special SSI Concerns

HCFA-AT-78-43 — Medicaid QC

HCFA-AT-78-44 — Public Notice of Changes in the Method or Level of Reimbursement for Health Care Services

HCFA-AT-78-45 — Clarification of Setting Medically Needy Resource Levels in 209(b) States

HCFA-AT-78-46 — Implementation of Guidelines for Medicaid Interagency Agreements

HCFA-AT-78-47 — Title XIX, Social Security Act: General Administration—Public Assistance Programs—Correction of Final Rule

HCFA–AT–78–48	— Title XIX, Social Security Act: Coverage and Conditions or Eligibility for Medical Assistance—Correction of Final Rule
HCFA–AT–78–49	— Revised Reporting Requirements for HCFA–2082: Annual Statistical Report on Medical Care
HCFA–AT–78–50	— HEW Study of In-Home Services (Section 18, P.L. 95–142)
HCFA–AT–78–51	— MMB Medical Assistance Manual: Update of Guides on Transportation for Recipients of Medical Assistance
HCFA–AT–78–52	— Correction to Preprinted State Plan Amendment on Medicaid Quality Control Systems (HCFA–AT–78–30 (MMB))
HCFA–AT–78–53	— Suspension of Physicians and Other Individual Practitioners Convicted of Crimes Related to Medicare or Medicaid
HCFA–AT–78–54	— Utilization Review
HCFA–AT–78–55	— New Directions for Skilled Nursing and Intermediate Care Facilities: Notice of Public Meetings
HCFA–AT–78–56	— Program Suspension for Physicians and Other Practitioners Convicted of Medicaid or Medicare Related Offenses; Reporting Requirements
HCFA–AT–78–57	— Limitations on Payment or Reimbursement for Drugs; Abolition of Advisory Committee
HCFA–AT–78–58	— Early and Periodic Screening, Diagnosis and Treatment Program Improvement Plan
HCFA–AT–78–59	— Screening, Detection, and Treatment of Undue Absorption and FFP for the Treatment of Undue Lead Absorption
HCFA–AT–78–60	— Reporting on Medicaid Fraud and Abuse Cases
HCFA–AT–78–61	— Relationship with PSRO's; Implementation of Section 5(d) of P.L. 94–142
HCFA–AT–78–62	— Reduction of FFP for Erroneous Payments
HCFA–AT–78–63	— Medicaid Fraud and Abuse Case File Retention Period
HCFA–AT–78–64	— Medicaid Eligibility—Technical Amendments

HCFA–AT–78–65 — Rural Health Clinic Services

HCFA–AT–78–66 — Regulations regarding Federal Funding of Abortions

HCFA–AT–78–67 — Extension of Reporting Regulation for Quarterly Statements of Financial Plan

HCFA–AT–78–68 — Reporting Related to Abortions Federally Funded Under Title XIX, Form HCFA–58

HCFA–AT–78–69 — State Plan Preprint: Rural Health Clinic Services—Medicaid

HCFA–AT–78–70 — State Medicaid Fraud Control Units

HCFA–AT–78–71 — Utilization Control (UC) Validation Survey for the Quarter Ending June 30, 1978

HCFA–AT–78–72 — Lowest Charge Level for Medical Services, Supplies and Equipment

HCFA–AT–78–73 — Disclosure of Information

HCFA–AT–78–74 — Update to Medicaid Quality Control Manual

HCFA–AT–78–75 — Residence

HCFA–AT–78–76 — Abolition of Pharmaceutical Reimbursement Advisory Committee (MAC Drugs)

HCFA–AT–78–77 — Federal Funding of Abortions, Title XIX

HCFA–AT–78–78 — Fiscal Disallowance for Erroneous Payments: Extension of Comment Period

HCFA–AT–78–79 — Timely Payment of Medicaid Claims

HCFA–AT–78–80 — Preprinted State Plan Amendments on Explanation of Benefit Notices and Funding of Fraud Control Units

HCFA–AT–78–81 — Reimbursement for Rural Health Clinic Services

HCFA–AT–78–82 — Grants to States for Medical Assistance Programs

HCFA–AT–78–83 — Assignment of Rights to Benefits, Collection of Medical Support and Other Third Party Liability Payments

HCFA–AT–78–84 — Medical Assistance Manual: Coverage Prior to Application for Medicaid

HCFA–AT–78–85 — Reimbursement for Hearing Aids and Eyeglasses

HCFA–AT–78–86 — Quarterly Statement of Financial Plan

HCFA–AT–78–87 — Protection of Patient's Funds

HCFA–AT–78–88	— Federal Percentages and Federal Medical Assistance Percentages for Federal Fiscal Years 1980 and 1981
HCFA–AT–78–89	— Convicted Physicians or Practitioners Suspended or Persons or Providers Excluded from the Medicare and Medicaid Programs
HCFA–AT–78–90	— Reorganization and Redesignation of Current Medicaid Regulations
HCFA–AT–78–91	— Medicaid Eligibility: Technical Amendments
HCFA–AT–78–92	— Conditions for Federal Financial Participation in the Cost of ADP
HCFA–AT–78–93	— Imposition of Sanctions on Health Care Practitioners
HCFA–AT–78–94	— Screening Guidelines and Payment Limit for Medicare and Medicaid Reimbursement of Rural Health Clinic Services
HCFA–AT–78–95	— Revisions to the Instructions for Preparation of the Quarterly Statement of Expenditures for the Medical Assistance Program Approved Under Title XIX
HCFA–AT–78–96	— Form HCFA–65, Quarterly Estimate of Expenditures
HCFA–AT–78–97	— Medicaid Utilization Control
HCFA–AT–78–98	— Validation Survey for the Quarter Ending September 30, 1978, in the Following 10 States: RI, NJ, DC, MI, OH, LA, KS, ND, NV, and ID
HCFA–AT–78–99	— Federal Financial Participation in State Claims for Sterilizations
HCFA–AT–78–100	— Reserved Bed Days
HCFA–AT–78–101	— Revision of State Plan Preprint (Information Requested)
HCFA–AT–78–102	— Inclusion of Penalty Statements on Provider Cost Reports
HCFA–AT–78–103	— Options for Reporting MQC Six-Month Summary Data
HCFA–AT–78–104	— Relationship of Part B of the Education of the Handicapped Children Act to Services in Title XIX ICFs

Information Memoranda

The Information Memoranda are policy instructions and other informational material as deemed necessary to Medicaid Program participants regarding certain aspects of the program that should be emphasized and elaborated upon because of problems which have been pointed out. A numeric listing of the Information Memoranda issued through November 30, 1978 follows:

HCFA-IM-78-3	—	The Development of Medicaid Performance Standards
HCFA-IM-78-4	—	Availability of Reports: Comprehensive Review of Medicaid Eligibility
HCFA-IM-78-5	—	10th Annual Conference of State Medicaid Directors
HCFA-IM-78-6	—	Postponement and Relocation of MARS-SUR Workshops
HCFA-IM-78-7	—	Regulation Proposal Summaries on the Medicare—Medicaid Anti-Fraud and Abuse
HCFA-IM-78-8	—	Regulation Proposal Summaries
HCFA-IM-78-9	—	Corrective Action Plan Development and Approval
HCFA-IM-78-10	—	Pharmaceutical Reimbursement Advisory Committee
HCFA-IM-78-11	—	HCFA Rulings
HCFA-IM-78-12	—	IMM Clearinghouse
HCFA-IM-78-13	—	Workshops on Revised Sampling and Review Requirements of the MQC System
HCFA-IM-78-14	—	Annual Conference of State Medicaid Consultants
HCFA-IM-78-15	—	Limitation on Payment of Reimbursement (Refer to SRS-AT-71-72 (MSA))
HCFA-IM-78-16	—	UNICEF—Sponsored International Year, the Child (TYC)
HCFA-IM-78-17	—	Clarification of Previous Information Transmitted Concerning Final FDA Regs on Hearing Aid Services (Refer to HCFA-IM-77-58)
HCFA-IM-78-18	—	Medicaid Manual: Training Contracts
HCFA-IM-78-19	—	Developmental Review in EPSDT Program
HCFA-IM-78-20	—	Clarification of Immunization Progress Reporting in the HCFA-120, Part 3 (Refer to HCFA-AT-77-117)
HCFA-IM-78-21	—	Medicaid Bill Processing System Test (BPST)
HCFA-IM-78-22	—	1978-79 IMM Schedule of Workshops and Conferences: Request for Subject-Area Recommendations

HCFA-IM-78-23 — List of Single State Agency Directors and Medical Assistance Unit Directors (Supersedes IM-77-69)

HCFA-IM-78-24 — Tech. Assistance for Preparation of State Plans to Monitor SRUs

HCFA-IM-78-25 — Disclosure of PSRO Data and Information to State Medicaid Agenda

HCFA-IM-78-26 — National Symposium on Medicaid for State Legislators and Other Public Officials

HCFA-IM-78-27 — Reporting Related to Abortions Financed Under Medicaid

HCFA-IM-78-28 — Announcement of Seminar for Public Sector Trainers, Chicago, Ill. June 16/17, 1978

HCFA-IM-78-29 — Training Sessions on Medicaid Fraud and Abuse (Refer to HCFA-IM-77-13)

HCFA-IM-78-30 — Request for Proposals for HCFR R & D Grants in Relation to EPSDT

HCFA-IM-78-31 — Tailoring Health Services to Individual Needs—Conference for State Staff

HCFA-IM-78-32 — Release of Confidential Information for Administrative Purposes—Definition of Administrative Purposes

HCFA-IM-78-33 — List of Single State Agency Directors and Medical Assistance Unit Directors

HCFA-IM-78-34 — Uniform Hospital Bill, UB-16

HCFA-IM-78-35 — Focal Point for IMM Activities in States

HCFA-IM-78-36 — Eleventh Annual Conference of Medicaid Directors

HCFA-IM-78-37 — Maximum Allowable Cost Program

HCFA-IM-78-38 — IMM Calendar of Activities

HCFA-IM-78-39 — Medicaid Corrective Action Project

HCFA-IM-78-40 — Second Options under Title XIX, SSA for Recommended Medical Care

HCFA-IM-78-41 — Medicaid Orientation Training Workshop

HCFA-IM-78-42 — Regulation proposal summary:
—ESRD Amendments
—Review of PRRB Decisions
—Hospital Insurance: Entitlement
—Conditions of Participation: Hospitals
—Conditions of Participation: SNFs and ICFs

HCFA–IM–78–43 — Medical Assistance Manual: Table of Contents

HCFA–IM–78–44 — Third Party Request for HCFA -50-51 Reports

HCFA–IM–78–45 — List of Single State Agency Directors and Medical Assistance Unit Directors

HCFA–IM–78–46 — Collaboration between DHEW and DHUD to Improve the Delivery of EPSDT Services to Eligible Children in Public Housing

HCFA–IM–78–47 — New Procedures for Public Access to Nursing Home Deficiency Reports

HCFA–IM–78–48 — Medical Recipient's Freedom of Choice of Medical Providers and State's Right to Centralize Purchasing of Medical Supplies and Equipment Loan Closets

HCFA–IM–78–49 — Regulation Proposal Summarizes
—Cost to related organizations
—Withholding of payments to providers of services and other suppliers of services
—Fraud in the Medical Assistance Program verification of services
—Recovery and Sanctions—Medicaid

HCFA–IM–78–50 — Implementation of ICD–9–CM in State Medicaid Information Systems

HCFA–IM–78–51 — Medicare and Medicaid Contracting

HCFA–IM–78–52 — Medicare and Medicaid Hospice Demonstration Projects

HCFA–IM–78–53 — Development of Training Package for Independent Professional Review Teams and Surveyors

HCFA–IM–78–54 — Immunization Initiative EPSDT

POLICY INTERPRETATION QUESTIONS

The Policy Interpretation Questions (PIQs) are a series of policy interpretations responded to by the Medicaid Bureau (and formerly the Social and Rehabilitation Service which was abolished by the Reorganization Order of the Secretary of March 8, 1977), pertaining to issues which need to be clarified in administering the Medicaid program. A numeric listing of

those Policy Interpretation Questions issued through November 30, 1978 * follows:

SRS–PIQ–77–11	— Processing Submittals of State Plans and Amendments
SRS–PIQ–77–12	— State Responsibility to Process Medicaid Applications Pending SSI Eligibility
SRS–PIQ–77–13	— Medicaid Eligibility—Resources of Institutionalized Individuals
SRS–PIQ–77–14	— SRS Policy Regarding Transfer of Property in Determining Medicaid Eligibility
SRS–PIQ–77–17	— Determining Eligibility for Family Planning Services
SRS–PIQ–77–18	— Administrative Period in Determining a Case Error for Quality Control Purposes
SRS–PIQ–77–23	— Treatment of Income in Redetermining Medicaid Eligibility for Indochinese Refugees as Medically Needy
SRS–PIQ–77–28	— Clarification of 45 CFR 205.10 and Determination of Overpayment and How It Relates to Medicaid Eligibility of Individuals Who Attained Eligibility Through Spend-Down
SRS–PIQ–77–29	— Coverage of Optional Services Under Title XIX
SRS–PIQ–77–33	— Withholding Medicaid FFP Under Section 1122—Capital Expenditures
SRS–PIQ–77–34	— Medicaid Eligibility—Clarification of 45 CFR 206.10(a)(6)—Medicaid Entitlement and Other Related Administrative Regulations
SRS–PIQ–77–35	— Application of SSI Criteria in Determining Medicaid Eligibility for Couples Under Provisions of 45 CFR 248.2(e)
SRS–PIQ–77–42	— Impact of Federal Participation in Costs of a Determination by the Secretary that a Nursing Facility Provider Agreement is Invalid in Accordance with the Provisions of 45 CFR 249.10(b)(4)(i)(C) or 249.10(b)(15)(vi)

* As of 12/1/78, the Regional Office Manual and Regional Letter systems replaced the PIQs.

SRS–PIQ–77–43 — Payment of Split Claims Under the Medically Needy Spenddown Procedure

SRS–PIQ–77–45 — Medicaid Eligibility and Personal Needs During the Month of Institutionalization

SRS–PIQ–77–46 — Computerized Axial Tomography CAT Scanner Reimbursement Outside the Hospital Setting

SRS–PIQ–77–47 — Allowability of FFP During Provisional Status of a Health Maintenance Organization

SRS–PIQ–77–49 — Medicaid Eligibility—Income Disregards in Approvable State Supplementary Payment (SSP) Programs

SRS–PIQ–77–50 — Federal Regulations Concerning Advance Notice and Hearing Procedures on an Adverse Action Taken on a Recipient's Case

SRS–PIQ–77–55 — Waiver If Enrollment Mix Requirements for Health Maintenance Organizations Under Section 202 of P.L. 94–460

SRS–PIQ–77–56 — The Medicaid Enumeration Process

SRS–PIQ–77–61 — Medicaid/EPSDT—Requirement for Informing Non-English Speaking/Reading Eligibles

SRS–PIQ–77–62 — Conditions of Medicaid Coverage for SSP Recipients

SRS–PIQ–77–63 — Consideration of Unpaid Expenses Which Are the Current Liability of the Recipient in Computing Medically Needy Spend-Down Liability

SRS–PIQ–77–67 — Medicaid Eligibility—Applicability of Special Income Standards for Institutionalized Persons To Those Receiving Short-Term Hospital Care

SRS–PIQ–77–68 — Prior Approval of Contracts or Expenditures

SRS–PIQ–77–69 — Limitations on Prescription Drugs

SRS–PIQ–77–70 — Massachusetts' Administratively Necessary Days Policy

SRS–PIQ–77–74 — Medicaid/EPSDT – Screening for Dental, Vision, and Hearing Problems

SRS–PIQ–77–75	— Classification of Errors in the Application of Excess Income for Institutionalized Cases as Liability Errors in MEQC—Your Memorandum Dated April 13, 1977
SRS–PIQ–77–77	— Determination of a Medically Needy Income Level for Two Adults
SRS–PIQ–77–81	— Requirements for Adequate and/or Timely Notice for Level of Care Changes Generated by Utilization Review, Medical Review, and Independent Professional Review Processes
MMB–PIQ–77–1	— Deleading the Home Environment as a Preventive Health Service
MMB–PIQ–77–2	— Reimbursement for Outpatient Psychiatric Services under Title XIX (Region VI Memo of March 24, 1977)
MMB–PIQ–77–3	— Medicare Part B—Enrollment for Eligible Recipients for the Medically Needy
MMB–PIQ–77–4	— Clarification of Three Months' Retroactive Provision Under Title XIX
MMB–PIQ–77–5	— Cost Containment in ICF Care
MMB–PIQ–77–6	— Full-Month Title XIX Coverage of Those Who are Partial-Month Inmates of a Public Institution
MMB–PIQ–77–7	— Methods and Standards for Setting Reasonable Cost Related Payment Rates for LTC Facilities under Section 1902(a)(3)(E) of the Social Security Act and 45 CFR 250.30 (a)(3)
MMB–PIQ–77–8	— Medicaid/EPSDT—Referrals from Screening to Diagnosis and Treatment
MMB–PIQ–77–9	— Medicaid Increased Federal Matching for CAP Agencies Carrying Out Approved EPSDT Health-Related Support Services
MMB–PIQ–77–10	— Medicaid Eligibility: Protection of Income and Exclusion of the Home as a Countable Resource for Dependents Residing in the Home of an Institutionalized Individual
MMB–PIQ–77–11	— Treatment of Money Received under the Uniform Relocation Assistance and Real Property Policies Act of 1970
MMB–PIQ–77–12	— Medicaid Eligibility: Spend-Down of Twenty Percent Title II Increase

MMB–PIQ–77–13	— Clinic Services—Exclusion from Coverage
MMB–PIQ–77–14	— Audits to Determine Reasonable Cost
MMB–PIQ–77–15	— Medicaid Supplementation: Payment by a Recipient's Relative or other Third Party for a Private Room
MMB–PIQ–78–1	— Consideration of Indian Claims Funds in Determination of Financial Eligibility for Medicaid
MMB–PIQ–78–2	— Medicaid Eligibility—Medically Needy—Clarification of Retroactive Spend-Down Policy
MMB–PIQ–78–3	— Medicaid-Inpatient Hospital Reimbursement —Costs of New Services
MMB–PIQ–78–4	— Medicare Profiles as They Apply to Medicaid Upper Limits
MMB–PIQ–78–5	— Medicaid Coverage of Persons in Certain Private Institutions
MMB–PIQ–78–6	— Medicaid Eligibility—209(b) Option
MMB–PIQ–78–7	— Medicaid Coverage During Month in Which an Individual Enters a Public Institution
MMB–PIQ–78–8	— Clarification of Upper Limit Requirements on FFP in 42 CFR 405.30(d)(1) (formerly 45 CFR 205.30(d)(1))
MMB–PIQ–78–9	— Reimbursement of Physician Services
MMB–PIQ–78–10	— Medicaid Eligibility of Individuals in Custody of a Penal System Who Are Committed to Public Institutions
MMB–PIQ–78–11	— Consideration of Variations Between Shelter Costs When Establishing Medically Needy Income Levels
MMB–PIQ–78–12	— Medicaid Eligibility-Medicare Part B Enrollment for the Medically Needy
MMB–PIQ–78–13	— Coverage of AFDC Caretaker Relatives under Title XIX When the Dependent Child(ren) in the Family Unit Receives SSI Benefits
MMB–PIQ–78–14	— Treatment of Third-Party Payments as They Affect Interim Payment Rates for Inpatient Hospital Services
MMB–PIQ–78–15	— Disregard of OASDI Cost-of-Living Increase

MMB–PIQ–78–16	— Handling of Excess Income (Partial Month Institutionalization)
MMB–PIQ–78–17	— Medicaid Eligibility—Application of Expenses Incurred in a Licensed Non-Participating Nursing Home Toward Spend-Down
MMB–PIQ–78–18	— Medicaid Coverage of Part B Benefits in a Buy-In State
MMB–PIQ–78–19	— Medicare Part B Enrollment for Eligible Recipients of Medicaid for Categorically Needy
MMB–PIQ–78–20	— Application of Third Party Resources for Inpatient Hospital Services—Additional Information
MMB–PIQ–78–21	— Financial Participation Rate for the Costs of Providing Medicaid Services Where the Function is Located in an Administrative Unit of the State Medicaid Agency
MMB–PIQ–78–22	— PIQ—Assurance of Medicaid Transportation
MMB–PIQ–78–23	— Title XIX EPSDT Federal Financial Participation for Operating and Equipping Screening and Publicity Vans
MMB–PIQ–78–24	— PIQ: Exclusion of FFP in Payments Under a Health Contract for Ineligible Recipients
MMB–PIQ–78–25	— Request for Additional Interpretation of PIQ–76–194: Medicaid Reimbursement of PHS-Supported and Other Public Clinics
MMB–PIQ–78–26	— Definition of Skilled Medical Professionals and Supporting Staff
MMB–PIQ–78–27	— Medicaid Coverage of Part B Benefits in a Buy-In State—PIQ No. 78–18 Dated July 7, 1978
MMB–PIQ–78–28	— Nursing Home Prepayments and Deposits
MMB–PIQ–79–1	— Regulations Dealing with Timely and Adequate Notice to SSI Recipients

FIELD STAFF INFORMATION AND INSTRUCTION SERIES

The Field Staff Information and Instruction Series (FSIIS) is designed to send general information, request multi-regional information and provide a method for systematic issuance of instructions. As of December 1,

1978, the Regional Office Manual and Regional Letter systems replaced the FSIIS. A numeric listing of FSIIS issued through 11/30/78 follows:

FSIIS–1 — New Issuance System (8/31/71)

FSIIS–2 — Sections of H.R. 1—Issue Papers (9/30/71)

FSIIS–3 — Substantiation of HEW Approval of State Medicaid Cutbacks (11/5/71)

FSIIS–4 — Section of H.R. 1—Issue Paper, 11/2/71

FSIIS–5 — SSA Referrals of Complaints on Nursing Homes (11/5/71)

FSIIS–6 — Semi-Annual Meeting of Associate Regional Commissioners for Medical Services (12/8/71)

FSIIS–7 — Forms for Reporting by the States of the Number of Mentally Retarded Provided Care in State Institutions and in Nursing Homes outside of . . . . (12/10/71)

FSIIS–8 — Assistance in Implementing the Dental Care Provision of Early Screening, Diagnosis, and Treatment of Individuals Under Age 21 (12/13/71)

FSIIS–9 — Medicaid Skilled Nursing Home Survey Report (12/16/71)

FSIIS–10 — Medicaid Administrative Cost Survey (12/22/71)

FSIIS–11 — Technical Assistance Series Manuscripts, (12/21/71)

FSIIS–12 — Technical Assistance Series Manuscript (12/29/71)

FSIIS–13 — Draft Report of the Medical Services Group of the Welfare Reform Planning Task Force (12/30/71)

FSIIS–14 — Updating Chart "Medicaid Services State by State" (1/18/72)

FSIIS–15 — Medicaid Administrative Costs (1/20/72)

FSIIS–16 — Meeting of Associate Regional Commissioners for Medical Services—April 18–20, 1972 (2/4/72)

FSIIS–17 — Impact of the Wage-Price Freeze on Medicaid Reimbursement (2/17/72)

FSIIS–18 — Medicaid Reimbursement Under Phase II of the Wage-Price Freeze

FSIIS–19 — Report Form for Fire-Safety Surveys of Extended Care Facilities and Skilled Nursing Homes (3/13/72)

FSIIS–20 — Medicaid Administrative Costs (3/13/72)

FSIIS–21 — Extended Care Facilities Participating in Title XVIII (3/14/72)

FSIIS–22 — Meeting of State Medicaid Dental Consultants in Washington, D.C. on May 19–20, 1972 (3/15/72)

FSIIS–23 — Licensure Programs for Nursing Home Administrators (3/20/72)

FSIIS–24 — Coordination with HEW Audit Agency Planning (3/20/72)

FSIIS–25 — Surveyor Training Status (3/22/72)

FSIIS–26 — SRS Collaboration with the 1972 Summer Health Start Program (3/23/72)

FSIIS–27 — Survey of ICF Amendments to State Title XIX Plans (3/29/72)

FSIIS–28 — Waiver Authority of Life Safety Code (3/30/72)

FSIIS–29 — State Reports on the Mentally Retarded in State Institutions or Placed in Nursing Homes Outside Institutions for Whom Federal Financial Participation Will Be Claimed Under Title XIX (4/3/72)

FSIIS–30 — Division of Program Monitoring Reorganization (4/12/72)

FSIIS–31 — Implementation of Life Safety Code (4/11/72)

FSIIS–32 — Indexes of Various Issuance Systems (4/13/72)

FSIIS–33 — Handbook Supplement D—March 1972 (4/14/72)

FSIIS–34 — Report of HEW Child Health Policy Task Force (4/26/72)

FSIIS–35 — Status Report on MSA Involvement in Interagency Effort to Maximize Third Party Payment for Health Services Provided by Grant Supported Centers (5/1/72)

FSIIS–36 — Instruction to Applicants for Returning Form SRS/MSA–3 (LTC) "Nursing Home Application to Participate in the Medical Assistance Program (Title XIX)" (5/5/72)

FSIIS–37 — Status of Designations of Fire Authorities for LSC Surveys (5/12/78)

FSIIS–38 — State Standards Applied to Clinics for Recognition as Providers under Title XIX (5/12/72)

FSIIS–39 — Meeting with State Welfare Directors on ICF Issue Papers (5/17/72)

FSIIS–40 — Limitations on Granting of Waivers of Certain Provisions of the Life Safety Code —Joint Policy for Medicare and Medicaid Programs (5/25/72)

FSIIS–41 — Community Services Administration Report, "Public Assistance Social Services Related to Medicaid" (5/31/72)

FSIIS–42 — Title XIX—Fair Hearings—Requirement for Advance Notice and Continuation of Assistance—45 CFR 205.10(a)(5) and Fair Hearing Guides 6–30–20E and F (6/2/72)

FSIIS–45 — Summary of Regional Responses to Field Staff Information and Instruction Series #37 (6/23/72)

FSIIS–46 — Summary of Aged Mentally Ill Patients in State Institutions and Selected Data from Fiscal Information from State Maintenance of Effort Reports (6/20/72)

FSIIS–47 — Summary of Medical Assistance to the Mentally Retarded in State Institutions and in Nursing Homes outside of Institutions. (Refer to Field Staff Information and Instructions Series: #7 dated 12/10/71 and #29 dated 4/6/72.) (6/20/72)

FSIIS–48 — Early and Periodic Screening, Diagnosis and Treatment Status Report for each State (6/26/72)

FSIIS–49 — Implementation of Joint Medicare-Medicaid Fire Safety Policy (10/5/72)

FSIIS–50 — HSHMA Regional Survey of Participation in Skilled Nursing Home Effort (7/10/73)

FSIIS–51 — FECA Assistance to Regional Office Medical Services Staff (7/18/72)

FSIIS–52 — Title XVIII–XIX Coordination of Voluntary and Involuntary Terminations (7/19/72)

FSIIS–53 — State Medical Care Advisory Committees (7/20/72)

FSIIS–54 — Proposed Revision of Regulation Covering Utilization Review (7/21/72)

FSIIS–55 — General Installation Guide for Implementation of Title XIX Medicaid Management Information Systems (MMIS) (1/11/73)

FSIIS–56 — NFPA Training Course (7/31/72)

FSIIS–57 — Semi-Annual Associate Regional Commissioners Meeting October 30–31, 1972 (8/3/72)

FSIIS–58 — Summary of Waivers by State and by Type (8/4/72)

FSIIS–59 — The Role of the Office of Program Innovation in Early and Periodic Screening, Diagnosis, and Treatment (8/8/72)

FSIIS–60 — Report on Status of Early and Periodic Screening, Diagnosis and Treatment Program in Each State (8/9/72)

FSIIS–61 — Training Session on Early and Periodic Screening, Diagnosis and Treatment, August 17–18, 1972 (8/8/72)

FSIIS–62 — Extended Care Facilities Participating in Title XVIII (8/21/72)

FSIIS–63 — National Association of Directors of State Health Facility Licensure and Certification Programs—National Conference (8/22/72)

FSIIS–64 — Release of Compilation of Quarterly Compliance (8/25/72)

FSIIS–65 — Geographical and Functional Assignments of Regional Offices MS Professional Staffs (8/30/72)

FSIIS–66 — Draft Regulations on Contracts (8/30/72)

FSIIS–67 — Fifth Annual Conference of State Medicaid Program Directors and their key consultants (8/30/72)

FSIIS–68 — Central Office Staff Visits to Regional Offices (9/7/72)

FSIIS–69 — Early Screening Compliance Reporting (9/7/72)

FSIIS–70 — Completion of the Long-Term Care Checklist for Civil Rights—OPS Objective #3, (9/12/72)

FSIIS–71 — Application of Fire Safety Standards (9/14/72)

FSIIS–72 — Special Workshops for Monitoring Checklists September 21–22, 28–29, 1972 (9/15/72)

FSIIS–73 — Title XIX Agency Recommendation for Waiver (9/8/72)

FSIIS–74 — Consistency in Reporting EPSDT Compliance Questions (9/21/72)

FSIIS–75 — The Scope and Intent of Medical Review (10/6/72)

FSIIS–76 — Early and Periodic Screening, Diagnosis, and Treatment (10/4/72)

FSIIS–77 — Compliance with Title VI and Skilled Nursing Homes (10/5/72)

FSIIS–78 — Regional Office Work Plan for Fiscal Activity in the Medicaid Area—MSA Technical Assistance for Sub-Objective #4 od AEA Objective #6 (Formerly #10) (10/6/72)

FSIIS–79 — Proposed Policy for Titles XVIII–XIX Cost Sharing for Provider Surveys (10/10/72)

FSIIS–80 — Audit Follow-up (10/12/72)

FSIIS–81 — Agenda for Semi-Annual Meeting of Associate Regional Commissioners for Medical Services October 30–31, 1972 (10/17/72)

FSIIS–82 — Federal Financial Participation in Advance Payments for Title XIX Services (11/6/72)

FSIIS–83 — Fifth Annual Conference of State Medicaid Program Directors and Consultants (10/26/72)

FSIIS–84 — EPSDT Essential Data: Recommended Components in a Model Information System (11/13/72)

FSIIS–85 — Staff Assignments to Implement P.L. 92–603 (11/17/72)

FSIIS–86 — Updating Chart "Medicaid Services State by State" (11/17/72)

FSIIS–87 — Establishment of Target Goals for Numbers of Children Screened and Development of a Timetable for Reaching Those Goals (11/17/72)

FSIIS–88 — Effective Date, Family Planning Services (11/24/72)

FSIIS–89 — Implementation of Section 235, P.L. 92–603 (H.R. 1) (12/5/72)

FSIIS–90 — Mailing Instructions—MSA Plan Material (12/6/72)

FSIIS–91 — EPSDT Progress Report (12/8/72)

FSIIS–92 — Draft of Regulations Implementing P.L. 92–603 (12/11/72)

FSIIS–94 — EPSDT Technical Assistance Memorandum #1 (12/11/72)

FSIIS–95 — Disclosure of Validation Information to State Medicaid Agencies (12/11/72)

FSIIS–96 — Surveyors—Supervisor Courses in Management and Related Skills at the University of Oklahoma (12/15/72)

FSIIS–97 — Draft of Regulations Implementing P.L. 92–603 (12/19/72)

FSIIS–98 — Draft of Regulations Implementing P.L. 92–603 (12/21/72)

FSIIS–99 — Draft Preprinted State Plan for Medical Assistance Program (1/8/73)

FSIIS–100 — EPSDT Technical Assistance Memorandum #2, Background Data on Children and their Health Needs (1/11/72)

FSIIS–117 — Request for State Title XIX Signed Prepaid Contracts (2/12/73)

FSIIS–118 — Draft of Regulations Implementing P.L. 92–603 (2/13/73)

FSIIS–119 — Workshops for Regional Medical Services Staffs (2/14/73)

FSIIS–120 — Proposed Revision of 45 CFR 249.10(b) (7) Home Health Services (2/20/73)

FSIIS–121 — EPSDT Technical Assistance Memorandum #4 (2/16/73)

FSIIS–122 — Agenda, List of Documents and Materials for Use in Workshops (2/20/73)

FSIIS–123 — Draft of Proposed Program Regulations Guide Implementing Section 235 of P.L. 92–603 (3/22/73)

FSIIS–124 — 1. State Annual Reports on the Aged Mentally Ill, OMB #83–RO277
2. State Annual Reports on the Mentally Retarded, OMB #93–RO241 (2/26/73)

FSIIS–125 — MSA Issuance Related to EPSDT (3/1/73)

FSIIS–126 — Summary of Progress of Implementation of EPSDT as of January 1973 (3/8/73)

FSIIS–127 — Schedule of University Surveyor and Supervisor Courses (3/15/73)

FSIIS–128 — Revision in Due Date for FSIIS #124, (3/15/73)

FSIIS–129 — Implementation of Section 209(b), P.L. 92–603 (H.R. 1) Medicaid Eligibility for Adults: Issue Paper (3/19/73)

FSIIS–130 — Form SRS–NCSS–116, Statistical Report on Numbers of Individuals Receiving EPSDT, (3/21/73)

FSIIS–131 — Hemodialysis—*Answers to Your Questions About HR–1* (3/27/73)

FSIIS–132 — HEW Audits in Progress (3/28/73)

FSIIS–133 — Corrections and Additions to FSIIS #126 (EPSDT Progress (4/2/73)

FSIIS–134 — Request for Characteristics of Prepaid Health Plans (3/30/73)

FSIIS–135 — Interpretation of Provisions of P.L. 92–603 Related to Medicaid Eligibility, (3/29/73)

FSIIS–136 — Federal Financial Participation in Administrative Costs for Persons Not Eligible for Title XIX Assistance (P.L. 92–603, Section 230) (4/2/73)

FSIIS–137 — Summary Statement of Findings Provided by Checklists and Detailed Data by Region, (4/17/73)

FSIIS–138 — Copies of APA Report on States' Activities to implement Subject Areas Affected by 1960–1967 Amendments to the Social Security Act (4/12/73)

FSIIS–139 — Reimbursement Under Title XIX for Services to the Chronically Ill and Impaired in Alternative Settings (4/9/73)

FSIIS–140 — State Reporting Deficiencies on Form SRS–NCSS–2082 (4/18/73)

FSIIS–141 — Regional Staff Meetings on Life Safety Code Surveys (4/19/73)

FSIIS–142 — Impact on States of Section 249D of P.L. 92–603 (4/20/73)

FSIIS–142–A — Impact on States of Section 249D of P.L. 92–603 (4/26/73)

FSIIS–143 — Early and Periodic Screening, Diagnosis, and Treatment—Sickle Cell Screening, (4/30/73)

FSIIS–144 — Draft of Regulation Implementing P.L. 92–603 (4/25/73)

FSIIS–145 — Hand-Outs for Surveyor Training Courses, (4/26/73)

FSIIS–146 — SRS/SSA Agreement on Federal Determination of Medicaid Eligibility (5/2/73)

FSIIS–147 — Implementation of Medical Review Requirements, 45 CFR 250.23 (4/30/73)

FSIIS–148 — Request for Information Regarding the Licensure Program for Nursing Home Administrators (4/30/73)

FSIIS–149 — Title XIX Coverage for Blind or Disabled Children Eligible to Receive SSI Benefits as of January 1, 1974 (5/10/73)

FSIIS–150 — NWRO Legal Committee Request for Information on EPSDT (5/11/73)

FSIIS–151 — Questions and Answers Relating to the Application of the NFPA Life Safety Code to the Medicaid and Medicare Programs, (5/14/73)

FSIIS–152 — Decisions Concerning Medicaid Eligibility Provisions (5/16/73)

FSIIS–153 — List of AAP Regional Liaison Appointees for Title XIX EPSDT (5/22/73)

FSIIS–154 — Information Distributed by SSA on Medicaid Costs (5/29/73)

FSIIS–155 — Department Policy Regarding Medicaid Eligibility Provisions of P.L. 92–603, (5/29/73)

FSIIS–156 — Explanation of Establishment of Target Goals for Numbers of Children Screened Under EPSDT: FSIIS #87 (6/8/73)

FSIIS–157 — EPSDT Program Descriptions (Positive Program Practices) (6/8/73)

FSIIS–158 — EPSDT Progress Report as of 3/31/73, (6/8/73)

FSIIS–159 — Addition to FSIIS #155 (Departmental Policy Regarding Medicaid Eligibility Provisions P.L. 92–603) (6/13/73)

FSIIS–160 — Draft of Regulation Implementing P.L. 92–603 (6/19/73)

FSIIS–161 — Regional Involvement in Professional Standards Review (6/20/73)

FSIIS–162 — Draft of Proposed Rule Making Implementing Section 208 of P.L. 92–603 (Cost Sharing) (6/21/73)

FSIIS–163 — Progress Report on Draft Preprinted State Plans for Medical Assistance Program, (6/27/73)

FSIIS–164 — Draft of Regulations Implementing P.L. 92–603 (7/3/73)

FSIIS–74–1 — Updated Information on the characteristics of State Medical Assistance Program, (7/2/73)

FSIIS–74–2 — Effect of Section 229, 230, and 275, P.L. 92–603, on Federal Financial Participation (7/3/73)

FSIIS–74–3 — Workshop on Medicaid, Eligibility July 23–24, 1973 (7/13/73)

FSIIS–74–4 — Telecopier Equipment (7/17/73)

FSIIS–74–5 — American Medical Association Meetings on PSROs (8/1/73)

FSIIS–74–6 — DHEW/State Meetings on PSRO Area Designations (8/7/73)

FSIIS–74–7 — Health Care Outreach Project, Filmograph, (8/9/73)

FSIIS–74–8 — Proposed Regulations for Supplemental Security Income (8/9/73)

FSIIS–74–9 — Sixth Annual Conference of State Medicaid Program Directors and Consultants, (8/10/73)

FSIIS–74–10 — MSA Semi-Annual Audit Conferences FY 1974 — OPS — MSA Objective 3 a Milestone D. 1 October 15–16 and 18–19, (8/13/73)

FSIIS–74–11 — MSA Meeting With State Medicaid Officials Regarding PSROs (8/14/73)

FSIIS–74–12 — Guidelines for Acceptance of Plastic Wastepaper Containers in Health Facilities, (8/16/73)

FSIIS–74–13 — Surveyor Training—University Courses—Last Course at U.C.L.A. (8/21/73)

FSIIS–74–14 — Use of Consultants by Regional Offices: EPSDT (8/24/73)

FSIIS–74–15 — Additional DHEW/State Meetings on PSRO Area Designations (8/24/73)

FSIIS–74–16 — Summary of Second EPSDT Progress Report for Period Ending June 20, 1973, (8/4/73)

FSIIS–74–17 — Medicaid Financial Review Objectives—Instructions and Suggestions for High Payoff Activity (9/11/73)

FSIIS–74–18 — Workshop on Section 1903(g) of the SSA (Utilization Review under section 207 of the 1972 Amendment) (9/6/73)

FSIIS–74–19 — Final Reports on Utilization Review and Civil Rights Checklists (9/7/73)

FSIIS–74–20 — Effect of the Supplemental Security Income Program on Health Insurance Buy-In, (9/20/73)

FSIIS–74–21 — Skilled Nursing Home Status Reports, (9/20/73)

FSIIS–74–22 — Sixth Annual Conference of State Medicaid Program Directors and Consultants, (9/20/73)

FSIIS–74–23 — Sixth Annual Conference of State Medicaid Program Directors and Consultants, (9/21/73)

FSIIS–74–24 — Contract SRS 72–64, Comparison of State Agency and Fiscal Agency Performance under Medicaid—Distribution of Final Report (9/25/73)

FSIIS–74–25 — Economic Stabilization Program (10/5/73)

FSIIS–74–26 — Additional Surveyor Courses at U.C.L.A., (10/5/73)

FSIIS–74–27 — Contract SRS 72–57, A Study of the Buy-In Provisions of the Medicaid Program—Distribution of Final Report (10/5/73)

FSIIS–74–28 — Professional Medical Review Workshops, (10/15/73)

FSIIS–74–29 — Additional PSRO Information (10/23/73)

FSIIS–74–30 — Cuba Checkerboard Rural Health Project—Filmograph (11/23/73)

FSIIS–74–31 — Burke Day Hospital Film (10/26/73)

FSIIS–74–32 — Interim Procedures for Issuing Time-Limited Agreements to SNF's (11/21/73)

FSIIS–74–33 — Title XIX Preprinted State Plans and Amendments—SRS Regional Office Procedures for Review and Action (11/12/73)

FSIIS–74–34 — Personal Needs Allowance to Institutionalized Title XIX Patients; Eligibility of Institutionalized Patients for $20 SSI Income Disregard (11/21/73)

FSIIS–74–35 — OPSR Memo—November 1973 (11/21/73)

FSIIS–74–36 — EPSDT Progress Report Update (12/7/73)

FSIIS–74–37 — Senate-passed technical and conforming amendments to Social Security Act, H.R. 3153 (12/12/73)

FSIIS–74–38 — Submission of Medicaid Preprinted Plan, (12/14/74)

FSIIS–74–39 — Request for State Definitions of Level of Care Determinations of Need for ICF Care, (1/2/74)

FSIIS–74–40 — Exemplary State HMO Guidelines, Model Contracts, and Reporting Requirements, (1/7/74)

FSIIS–74–41 — Limitation of Federal Participation for Capital Expenditures—Section 1122, SSA, (1/4/74)

FSIIS–74–42 — Summary of Status of Implementation of EPSDT for Quarter Ending September 30, 1973 (1/10/74)

FSIIS–74–43 — Final Regulations (Pending Clearance)—Medicaid Eligibility Under SSI (1/15/74)

FSIIS–74–44 — Referral of Medicaid Fraud Cases to the U.S. Attorney's Office (1/22/74)

FSIIS–74–45 — Provider Fraud and Abuse (1/28/74)

FSIIS–74–46 — Economic Stabilization Program (1/31/74)

FSIIS–74–47 — California Child Health Disability Prevention Act (2/4/74)

FSIIS–74–48 — Inventory of Prior Authorization Use, (2/21/74)

FSIIS–74–49 — Study of Cost Differentials between SNFs and ICFs—Distribution of Final Report, (2/28/74)

FSIIS–74–50 — Discontinuation of Reporting Required Under FSIIS–124, Mental Health (3/4/74)

FSIIS–74–51 — EPSDT Program Implementation Report, (3/8/74)

FSIIS–74–52 — Updating Chart "Medicaid Services State by State" (3/14/74)

FSIIS–74–53 — Final Report—Survey of LTC Facilities/Patients (4/1/74)

FSIIS–74–54 — EPSDT Implementation—Quarter Ending 12/31/73 (4/1/74)

FSIIS–74–55 — EPSDT Implementation Report—Corrections (4/4/74)

FSIIS–74–56 — Plans for Phasing Out ICF Supplementation (4/12/74)

FSIIS–74–57 — Questionnaire on Physicians' Reimbursement, Phys. Participation, and Special State Practices in Cost Control (4/19/74)

FSIIS–74–57–A — Meeting of State Dental Consultants, (4/22/74)

FSIIS–74–58 — Revised Objective 3a—FY74 MSA Objectives (4/24/74)

FSIIS–74–59 — Revision of Title XIX and Related Provisions of P.L. 92–603, 93–66, and 93–233—Working Document (4/24/74)

FSIIS–74–60 — Cost Benefit Analysis of UR Techniques—Report (4/30/74)

FSIIS–74–61 — Section 1122 Manual (Revised) (5/9/74)

FSIIS–74–62 — CLC Phase III and IV regulations—LTCs, (5/20/74)

FSIIS–74–63 — Revised Procedures for Termination of XIX Providers under Sec. 229(c) of P.L. 92–603 (5/24/74)

FSIIS–74–64 — ALERT—Alleged Fraud Practices in Medicaid (MHI) (5/24/74)

FSIIS–74–65 — Semi-Annual Meeting of ARCs for MS (5/28/74)

FSIIS–74–66 — Changes in EPSDT Report Form (6/10/74)

FSIIS–74–67 — Dental Services in EPSDT (Report of Survey) (6/11/74)

FSIIS–74–68 — Inf. on State Statutes and Reimbursement for SNFs and ICFs (6/24/74)

FSIIS–74–69 — Quarterly SNF Certification Reports (now with ONHA (6/28/74)

FSIIS–75–1 — FFP Suspensions (Sec. 290) (7/9/74)

FSIIS–75–2 — Information Required on Factoring and Time Lag in Vendor Payments (7/24/74)

FSIIS–75–3 — Transmittal of recent issuances of Div. of Comprehensive Health Planning, PHS, re Section 1122 (Capital Expenditures), (8/7/74)

FSIIS–75–4 — EPSDT Penalty Reporting Form (8/8/74)

FSIIS–75–6 — Preprint—Eligibility (8/22/74)

FSIIS–75–7 — Free Choice of Qualified Providers (9/3/74)

FSIIS–75–8 — Promulgation of Percentages (9/6/74)

FSIIS–75–9 — PSRO Reprint from SRS Record (9/18/74)

FSIIS–75–10 — Technical and Actuarial Assistance to States on HMOs (9/24/74)

FSIIS–75–11 — Postponement of Annual Conference of State Medicaid Director (9/26/74)

FSIIS–75–12 — Questionnaire—State Agency/Fiscal Agent Relationships (10/1/74)

FSIIS–75–13 — Survey of Reimbursement Methods for SNFs and ICFs (10/8/74)

FSIIS–75–14 — CHP issuances on Capital Expenditures Regulations (10/17/74)

FSIIS–75–15 — Preprint—Cost Sharing (10/21/74)

FSIIS–75–16 — Withholding FFP—Providers Suspended from Medicare (Sec. 290 Regulations)—No State Plan Amendment Needed, (10/25/74)

FSIIS–75–17 — State Plan Provisions (and other information) Requested by Martha Griffiths, (10/30/74)

FSIIS–75–18 — Amended cost sharing regulations—Correction of table (11/13/74)

FSIIS–75–19 — FMAPs—table of figures since 1/66, (11/13/74)

FSIIS–75–20 — Reimbursement and Other Policy on End-stage Renal Disease (12/12/74)

FSIIS–75–21 — State Review of RO Narrative Report—EPSDT (12/19/74)

FSIIS–75–22 — Treatment in Mental Hospitals for Individuals under 21—Maintenance of Effort—Request for comments from RO (12/20/74)

FSIIS–75–23 — Updating Chart "Medicaid Services State by State" (1/2/75)

FSIIS–75–24 — Memorandum of Agreement re Medical Services to Indians (1/8/75)

FSIIS–75–25 — Information on Reimbursement to Home Health Agencies (1/10/75)

FSIIS–75–26 — Review of Financial Review Guides, (1/13/75)

FSIIS–75–27 — 7th Annual Conference of State Medicaid Directors (1/23/75)

FSIIS–75–28 — EPSDT Penalty Procedures (2/3/75)

FSIIS–75–29 — List of Pages in Preprinted State Plan, (2/2/75)

FSIIS–75–30 — Draft Policy on Medical Care Equivalents to EPSDT (2/13/75)

FSIIS–75–31 — EPSDT Report Forms to be Used during FY 1975 (2/13/75)

FSIIS–75–32 — 7th Annual Conference of State Medicaid Directors (2/14/75)

FSIIS–75–33 — Cost Reporting Forms for SNFs and ICFs—Copies Requested (2/25/75)

FSIIS–75–34 — State Plan Amendments—Submittal to CO when received by RO (2/28/75)

FSIIS–75–35 — Seventh Annual Conference of State Medicaid Program Directors—Proposed Extended Session on Medicaid Elig. (3/4/75)

FSIIS–75–36 — Report on Status of State Medicaid Management—Due 3/14/75 (3/6/75)

FSIIS–75–36A — State Medicaid Staffing—Addendum, (4/7/75)

FSIIS–75–37 — Additional Fraud Information needed for Appropriations Hearings—Report due 8/18/75 (3/12/75)

FSIIS–75–38 — Memorandum of Agreement Re Provision of Medical Services to Indians and other Native Americans—Report by 4/21/75, (3/21/75)

FSIIS–75–39 — Suggestion for Limiting Use of Medicaid Cards for NH Services (3/25/75)

FSIIS–75–40 — EPSDT Statistical Reporting (3/21/75)

FSIIS–75–41 — Dental Consultants' Meeting—D.C.—5/16–17, 1975 (3/28/75)

FSIIS–75–42 — Follow-up to EPSDT Questions Raised at Denver Orientation (4/3/75)

FSIIS–75–43 — Tax Cut Bill P.L. 94–12 (4/8/75)

FSIIS–75–44 — Example of Sterilization Consent Forms in Compliance with 45 CFR 20–5.35 (4/9/75)

FSIIS–75–45 — Index of PIQs on Medicaid Eligibility, (4/16/75)

FSIIS–75–46 — Composition of State Boards for Licensure of Nursing Home Administrators (4/21/75)

FSIIS–75–47 — Guidelines on SNF/ICF Differential—Request for questions (5/1/75)

FSIIS–75–48 — Draft Residence Regulations—Request for comment (5/2/75)

FSIIS–75–49 — Status of State Implementation of Transportation Requirement (5/16/75)

FSIIS–75–50 — EPSDT Dental Workshop, Chicago, May 29–30, 1975 (5/20/75)

FSIIS–75–51 — Coordination of Regional Office Training: Long-term Care (5/21/75)

FSIIS–75–52 — Meeting of ARCs for Medical Services, (5/22/75)

FSIIS–75–53 — Plan Approved as Alternative Methods for Reimbursement of Inpatient Hospital Services; 45 CFR 250.30(a)(2) & (b)(1), (5/30/74)

FSIIS–75–54 — Correspondence with MSA Central Office, (5/30/75)

FSIIS–75–55 — Compliance Reporting (6/11/75)

FSIIS–75–56 — Utilization Review Guidelines for Skilled Nursing Facilities (6/17/75)

FSIIS–75–57 — Orientation for Regional and Central Offices—EPSDT Staff (6/17/75)

FSIIS–75–58 — MSA Orientation Material (6/17/75)

FSIIS–75–59 — Regional Fraud and Abuse Workshop—July 15–16 (6/25/75)

FSIIS–75–60 — Medically Needy Income Levels (6/27/75)

FSIIS–76–1 — Physician Earnings Under the Medicaid Program, CY 1974 (7/1/75)

FSIIS–76–2 — EPSDT Program Survey (7/9/75)

FSIIS–76–3 — EPSDT Technical Assistance Reference Materials (7/10/75)

FSIIS–76–4 — Follow-up to EPSDT Orientation and FSIIS 75–42 (7/16/75)

FSIIS–76–5 — Utilization Review Plan and Checklist/MR and IPR Survey Checklists (7/16/75)

FSIIS–76–6 — Submittal of State Plan Preprints on Eligibility (7/21/75)

FSIIS–76–7 — Medicaid Eligibility of Mandatory State Supplement Recipients (7/23/75)

FSIIS–76–8 — Updating chart "Medicaid Services State by State" (8/4/75)

FSIIS–76–9 — Second and Third Quarter EPSDT Reports, (7/31/75)

FSIIS–76–10 — Medicaid's Forward Plan (7/31/75)

FSIIS–76–11 — State Data Books (8/5/75)

FSIIS–76–13 — Draft Policy on Medical Care Equivalents to EPSDT and Statistical Reporting Requirements for Review and Comment, (8/12/75)

FSIIS–76–14 — EPSDT Working Sessions with Regional Staff (8/12/75)

FSIIS–76–15 — Clarification of the EPSDT Penalty Requirement for Annual Informing (8/13/75)

FSIIS–76–16 — Disregard of $50 Payments for Institutionalized Recipients (in reference to FSIIS 75–43 (8/13/75)

FSIIS–76–17 — Overview of Medicaid Provider Fraud and Abuse (8/29/75)

FSIIS–76–18 — Visits to States by Contractor (9/3/75)

FSIIS–76–19 — Need for Inflation Impact Statement for Implementing Section 249 of P.L. 92–603, (9/7/75)

FSIIS–76–19A — Need for Inflation Impact Statement for Implementing Section 249 of P.L. 92–603, (9/23/75)

FSIIS–76–20 — Increased Professional Provider Participation in State and Local EPSDT Programs, (9/8/75)

FSIIS–76–21 — Disallowance of FFP in State Medicaid Expenditures for Sterilization Procedures, (9/10/75)

FSIIS–76–22 — Availability of Film ABC News Closeup; Children in Neglect (9/25/75)

FSIIS–76–23 — Unnecessary Surgery (9/12/75)

FSIIS–76–24 — Reduction in Provider Fees (9/22/75)

FSIIS–76–25 — Meeting of Regional Prevention Division Directors (PHS) (9/22/75)

FSIIS–76–26 — Utilization Control Workshop (9/15/75)

FSIIS–76–27 — Report on Review of Sterilization Consent Forms (9/23/75)

FSIIS–76–28 — State Data Book Supportive Materials, (9/24/75)

FSIIS–76–29 — Regional Comments on Draft Quarterly Showing Format (9/24/75)

FSIIS–76–30 — South Carolina EPSDT Program (Best Practice Identification (9/26/75)

FSIIS–76–31 — Utilization Control Update (9/30/75)

FSIIS–76–32 — Fraud and Abuse Review Guide (9/30/75)

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FSIIS–76–34 — Out-of-State Institutional Patient Placement Assessment: UC Objective, Milestone K–3, (10/6/75)

FSIIS–76–35 — Third Party Liability—Use of Medicare Benefits in SNFs (10/21/75)

FSIIS–76–36 — State Plan Changes—Data for the Secretary (10/22/75)

FSIIS–76–37 — EPSDT Quarterly Reports for the First and Second Quarters FY 1976 (10/24/75)

FSIIS–76–37A — EPSDT Quarterly Reports for the Second and Third Quarters FY 1976 (4/28/76)

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FSIIS–76–49 — Medicaid Eligibility Training Workshops, (11/18/75)

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FSIIS–76–53 — Meeting of State Medicaid Podiatry Consultants in D.C. (11/28/75)

FSIIS–76–54 — Notice in Reduction in Medical Assistance (11/24/75)

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FSIIS–76–58 — Follow-up report on October UC Workshop (12/11/75)

FSIIS–76–59 — Analysis of Preliminary Program Survey for EPSDT Penalty (12/16/75)

FSIIS–76–60 — Information on Ordering Sterilization Consent Forms (12/19/75)

FSIIS–76–61 — Medicaid Eligibility Training Workshop—Seattle (12/30/75)

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FSIIS–76–73 — Eighth Annual Conference of State Medicaid Program Directors (2/4/76)

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FSIIS–76–91 — Request for Information Regarding ICF (Excluding IMR) Levels of Care (4/2/76)

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FSIIS–76–128 — Notification of Visits to States (7/7/76)

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FSIIS–76–152 — The Status of EPSDT Developmental Assessment in the States (9/10/76)

FSIIS–76–153 — Fraud and Abuse Control Seminar for the State Medicaid Program Directors and Medical Services Staff from the Regional Offices (9/14/76)

FSIIS–76–154 — Medicaid Eligibility Workshop (9/14/76)

FSIIS–76–155 — Regional Office Action States' Documentation on Waivers of 1861(k) (Follow-up on SRS–At–76–77) (9/14/76)

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FSIIS–77–15 — Report on Status of State Medicaid Staffing and Contracts for Program Administration (11/2/76)

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FSIIS–77–25 — Plans of Medicaid State Agencies to Monitor Conditional PSRO Performance (11/29/76)

FSIIS–77–26 — State Plan Amendments on "Consent to Suit" (12/6/76)

FSIIS–77–27 — Request for Information on Fiscal Agents Utilized by State Medicaid Agencies (12/15/76)

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FSIIS–77–30 — Exchange of Information Between SRS/MSA & SSA/BHI (1/3/77)

FSIIS–77–31 — Fraud and Abuse Control Regional Coordinators Meeting (1/15/77)

FSIIS–77–32 — Overdue Program Improvement Plans and Regional Coordinators Meeting (1/3/77)

FSIIS–77–33 — Compliance Report for the Quarter Ending September 30, 1976 (1/14/77)

FSIIS–77–34 — Developmental Disabilities Assistance and Bill of Rights Act, P.L. 94–103, "Projects of National Significance Grant Awards EPSDT Penalty Reconsideration Decisions (1/19/77)
(1/19/77)

FSIIS–77–35 — EPSDT Penalty Reconsideration Decisions

FSIIS–77–36 — Southern Council Report/New Releases (1/19/77)

FSIIS–77–37 — Update of the State Medical Assistance Program Characteristics Under title XIX of the SSA (1/25/77)

FSIIS–77–38 — Erroneous Payments Conference for Medical Services Staff from the Regional Offices State Claims Processing Managers and State Monitors of Fiscal Agents (1/27/77)

FSIIS–77–39 — Long Term Care Meeting (2/1/77)

FSIIS–77–40 — FY 77 OPS: Clarification of Objective Number 3 (2/1/77)

FSIIS–77–41 — Ninth Annual Conference of State Medicaid Program Directors (2/2/77)

FSIIS–77–42 — Memorandum of Understanding with the HEW Office of Investigations (2/4/77)

FSIIS–77–43 — Medicaid Legislation Information—H.R. 3 and S. 143 (2/7/77)

FSIIS–77–44 — Draft Summary of Recent Statutory Changes Affecting Medicaid Eligibility (2/7/77)

FSIIS–77–45 — Transmittal of the GAO Summary Report on "RETURNING THE MENTALLY DISABLED TO THE COMMUNITY: GOVERNMENT NEEDS TO DO MORE" and Medicaid's Comments (2/15/77)

FSIIS–77–46 — Regional Office Work Plan Guidance (2/17/77)

FSIIS–77–47 — Plans for Compliance of Indian Health Service Facilities: Due to Regional Office by March 31, 1977 (2/18/77)

FSIIS–77–48 — Single State Agency Plans for Monitoring Conditional PSROs (3/9/77)

FSIIS–77–49 — Request for Information on Selected Changes in State Medicaid Programs (3/11/77)

FSIIS–77–50 — UC Validation Survey of FY 76 and 77—Status of Implementation and Tentative Training (3/21/77)

FSIIS–77–51 — Appointment of Regional MSA/HURA Contact (3/21/77)

FSIIS–77–52 — Validation of EPSDT Program Data (3/22/77)

FSIIS–77–53 — Indian Health Service Facilities and Nondiscrimination (3/28/77)

FSIIS–77–54 — Coordination of Information Regarding Title *XVIII* Exclusions (3/29/77)

FSIIS–77–55 — Regional Fraud and Abuse Control Coordinators Meeting (3/29/77)

FSIIS–77–56 — Dismissal of American Medical Association (AMA) Pharmaceutical Manufacturers Association (PMA) Suit Against Maximum Allowable Cost (MAC) Regulations (4/1/77)

FSIIS–77–57 — Cases Assumed by the HEW Office of Investigations (4/1/77)

FSIIS–77–58 — State Reimbursement Plans for Long Term Care Facilities (4/1/77)

FSIIS–77–59 — State Reimbursement Plans for Long Term Care Facilities (4/4/77)

FSIIS–77–60 — UC Survey for FY 76–77: Training Session for UC Validation Survey (4/5/77)

FSIIS–77–61 — BHI Program Integrity Training Session (4/5/77)

FSIIS–77–62 — Medicaid Eligibility for Those Receiving Alternative to Long Term Care Services—Information (4/5/77)

FSIIS–77–63 — Report on Selected Changes in State Medicaid Programs (3/5/77)

FSIIS–77–64 — Conference Agenda, Registration Forms (4/5/77)

FSIIS–77–65 — Interim Information: Applications for Health Maintenance Organization Qualification and Waivers (4/12/77)

FSIIS–77–66	— Instructions for Utilization Control Survey of States' Adherence to Section 1903(g) of the SSA for FY 1976 and 1977 (4/15/77)
FSIIS–77–67	— Updating Chart "Medicaid Services State by State" (4/19/77)
FSIIS–77–68	— Revision of Sections on Financial Eligibility (4/19/77)
FSIIS–77–69	— Medicaid Fraud and Abuse Control Model Statute (4/20/77)
FSIIS–77–70	— State Fraud and Abuse Control Management Assessments (4/22/77)
FSIIS–77–71	— Medicaid—Financial Responsibility of Relatives (4/22/77)
FSIIS–77–71–A	— (Addendum) Medicaid—Financial Responsibility of Relatives and Administrative Costs for Recouping from Legally Liable Third Parties (6/13/77)
FSIIS–77–72	— Assessment of Independent Professional Review in Intermediate Care Facilities for the Mentally Retarded (4/29/77)
FSIIS–77–73	— Definitions for the Medicaid Minimum Data Set (5/9/77)
FSIIS–77–74	— Medicaid State Assessments (5/9/77)
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FSIIS–77–77	— State Reimbursement Plan for Long Term Care Facilities (5/23/77)
FSIIS–77–78	— State and Regional Coordination to Increase State Investigative Capabilities (5/24/77)
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FSIIS–77–81	State Data Books (6/1/77)
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FSIIS–77–83 — Revision of 45 CFR 248.3(b) (Consideration of Available Income and Resources of Applicants for or Recipients of Medical Assistance): Applicable SSI Deeming Regulations (6/1/77)

FSIIS–77–84 — Development of a Joint Federal/State/Local Medicare Investigative Task Force (6/14/78)

FSIIS–77–85 — Federal Financial Participation Through Title XIX for Drug Availability Studies (6/14/77)

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FSIIS–77–88 — Interagency Activity Related to EPSDT (6/28/77)

FSIIS–77–89 — Meeting Acting Regional Medicaid Directors (6/30/77)

FSIIS–77–90 — Development of State and Local training, FY 76 under Title IV–A, XIX and XX of the Social Security Act (7/7/77)

FSIIS–77–91 — State Plans for Reimbursement of Long Term Care Facilities (7/11/77)

FSIIS–77–92 — Comprehensive Mental Health Program Information (7/27/77)

FSIIS–77–93 — Request for Information Selected Changes in State Medicaid Programs (7/27/77)

FSIIS–77–94 — UC Survey of the 3rd Quarter of FY 77—Tentative Schedule and Staffing Needs (7/26/77)

FSIIS–77–95 — Supplementation: Requirements of 45 CFR 250.30(a)(8) With Respect to Government Operated Facilities and Institutions (7/28/77)

FSIIS–77–96 — Meeting of Acting Regional Medicaid Directors (8/3/77)

FSIIS–77–97 — Periodic Medical Review Regulations—Error in October 1, 1976 Code of Federal Regulations (8/8/77)

FSIIS–77–98 — Institute for Medicaid Management Meetings on Coordination of Federal/State Training Resources, Needs and Activity to Upgrade Staff Capability (8/10/77)

FSIIS–77–99 — Federal Financial Participation for JCAH Program/Facility Accreditation for Inpatient Services to Individuals under Age 21 (8/10/77)

FSIIS–77–100 — General Work Plan Guidance on IMM and State Assessments (8/16/77)

FSIIS–77–101 — HEW Immunization Initiative—Regional Meetings (8/18/77)

FSIIS–77–102 — Transmittal of Medicaid Data Report B–1, April 1977 (8/19/77)

FSIIS–77–103 — State Acceptance of Qualified IHS Facilities as Service Providers (8/22/77)

FSIIS–77–104 — 100% FFP to States Under Medicaid for Compensation of Inspectors Responsible for Maintaining Compliance with Federal Standards (8/25/77)

FSIIS–77–105 — Interpretation of 45 CFR 249.10(b)(3) and (5): AT 77–35 (MSA) (9/8/77)

FSIIS–77–106 — Overdue Medicaid Reports (8/25/77)

FSIIS–77–107 — Regional Central Office Conference on EPSDT (8/25/77)

FSIIS–77–108 — Full-time Permanent Ceilings (8/26/77)

FSIIS–77–109 — Information Regarding UC Material Discussed at Seattle Meeting (8/25/77)

FSIIS–77–110 — Information Regarding UC Material Discussed at Seattle Meeting (8/25/77)

FSIIS–77–111 — A Survey of State's Attitudes Toward the MMIS (9/15/77)

FSIIS–77–112 — Policy Clarification—MEQC Negative Case Action Quality Control NCAQC (9/21/77)

FSIIS–77–113 — Reimbursement Experiment for Durable Medical Equipment Through Medicare (9/22/77)

FSIIS–77–114 — Penalty Monitoring for the EPSDT Program (9/22/77)

FSIIS–77–115 — Contracts Requirements (45 CFR 249.82) Revocation of Policy Interpretation (9/26/77)

FSIIS–77–116 — Transmittal of Medicaid Data Report B–1, May 1977 (9/26/77)

FSIIS–77–117 — State Assessment Training for Regional Office Personnel (9/26/77)

FSIIS–77–118 — Change in Code of Federal Regulations—Medicaid Regulations (9/29/77)

FSIIS–78–1 — Correction of Action Transmittal—Reserved Beds Regulation (10/4/77)

FSIIS–78–2 — Medicaid Eligibility Workshop-Seminar (10/7/77)

FSIIS–78–2A — An Addendum to 78–2, Medicaid Eligibility Workshop/Seminar (10/31/77)

FSIIS–78–3 — Medicaid Eligibility Quality Control Implementation Plans for the October 1977–March 1978 Reporting Period (10/7/77)

FSIIS–78–4 — Meeting of Acting Regional Medicaid Directors (10/12/77)

FSIIS–78–5 — State Plan Monthly Status Report (10/12/77)

FSIIS–78–6 — Designations of Regional Officials—Medicaid Authority (10/14/77)

FSIIS–78–7 — Change in Effective Date of Contracts Regulation (45 CFR 249.82) (10/14/77)

FSIIS–78–8 — Medicaid Eligibility Quality Control (MEQC) Federal Differences and Submission of Reports (10/18/77)

FSIIS–78–9 — Medicaid Eligibility Quality Control (MEQC) Field Staff Meeting (10/18/77)

FSIIS–78–10 — Update to FSIIS FY–77–117, State Assessment Training for Regional Personnel (10/18/77)

FSIIS–78–11 — Personnel Ceilings (10/25/77)

FSIIS–78–12 — Request for Copies of all Billing Forms Used In State Medicaid Programs (10/27/77)

FSIIS–78–13 — Utilization Control: Instructions for Reviewing Showing Under Section 1903(q) for Quarter Ending 9/30/77 (11/1/77)

FSIIS–78–14 — Example of Sterilization Consent Form—Pamphlet on Hysterectomy (11/7/77)

FSIIS–78–15 — HEW Procedures for prior Approval of State Information Systems (11/9/77)

FSIIS–78–16 — Reasonable Charges for Prescribed Drugs; Survey of costs of pharmacy operation (11/9/77)

FSIIS–78–17 — Meeting of Acting Regional Medicaid Directors (11/10/77)

FSIIS–78–18 — Regional Analyses of OA–25 Estimates—DUE November 29, 1977 (11/10/77)

FSIIS–78–19 — State by State MEQC Error Rate (11/14/77)

FSIIS–78–20 — Medicaid Interagency Agreements Conference (11/15/77)

FSIIS–78–21 — State-by-State Summary of Data on Non-Federal Providers in Active Practice: Total and Number Participating in Title XIX (11/16/77)

FSIIS–78–22 — Report on Selected Changes in State Medicaid Programs (11/16/77)

FSIIS–78–23 — Utilization Control—Validation Survey of the September 30, 1977, Quarter (11/16/77)

FSIIS–78–24 — Utilization Control Conference (11/21/77)

FSIIS–78–25 — Medical Review in Skilled Nursing Facilities (11/29/77)

FSIIS–78–26 — Need for Information on State Medicaid Eligibility Programs (11/29/77)

FSIIS–78–27 — Medicaid Budgeting (12/6/77)

FSIIS–78–28 — Institute for Medicaid Management, Compendium of Health-Oriented Organizations/Associations/Agencies (12/6/77)

FSIIS–78–29 — Annual EPSDT Penalty Review Under Existing Regulations for Reviews Scheduled to Begin Before April 1978 (12/6/77)

FSIIS–78–30 — Final Regulation for Staffing and Training in Medical Assistance Programs: 42 CFR 446 (12/12/77)

FSIIS–78–31 — Request for Information on Selected Changes in State Medicaid Programs (12/19/77)

FSIIS–78–32 — PIQ Procedures (12/19/77)

FSIIS–78–33 — Discrimination Against the Handicapped—Methods of Administration (12/28/77)

FSIIS–78–34 — Meeting of the Acting Regional Medicaid Directors (12/29/77)

FSIIS–78–35 — Central/Regional Office Systems Staff Meeting (1/3/78)

FSIIS–78–36 — Correction of Cross-Reference Citations in Regulations (1/10/78)

FSIIS–78–37 — Acceptance of Indian Health Services Facilities as Medicaid Providers (1/10/78)

FSIIS–78–38 — Under Secretary's Decision on Cost Allocation and Other Financial Management Responsibilities Formerly Performed by SRS (1/11/78)

FSIIS–78–39 — Medicaid Interagency Relationships and Agreements Workshops (1/11/78)

FSIIS–78–40 — Regional Training and Technical Assistance Coordinators Meeting (1/11/78)

FSIIS–78–41 — Regulations Proposals on Certain Sections of P.L. 95–142, Medicare-Medicaid Anti-Fraud and Abuse Amendments (1/12/78)

FSIIS–78–42 — Utilization Control Training Session (1/17/78)

FSIIS–78–43 — Regional Staffing for EPSDT (1/17/78)

FSIIS–78–44 — Tenth Annual Conference of State Medicaid Directors (1/18/78)

FSIIS–78–45 — DFAFS Training for Regional and State Personnel Involved with Financial Reporting for Public Assistance Programs (1/23/78)

FSIIS–78–46 — List of Pages in Preprinted Medicaid State Plan (1/26/78)

FSIIS–78–47 — Regulation on State Medicaid Fraud Control Units (1/27/78)

FSIIS–78–48 — Regional Offices Memorandum to Central Office (1/27/78)

FSIIS–78–49 — Transmittal of Report: "Comprehensive Review of Medicaid Eligibility" (1/30/78)

FSIIS–78–50 — Utilization Control: Instructions for Reviewing States' Showings under section 1903(g) for Quarter Ending 12/31/77 (1/31/78)

FSIIS–78–51 — Personnel Ceilings (2/2/78)

FSIIS–78–52 — Updating Chart "Medicaid Services State By State" (2/7/78)

FSIIS–78–53 — PSRO Program Transmittal on Revision of Grace Period Requirements (2/13/78)

FSIIS–78–54 — OMB Reimbursement Rates for Outpatient and Inpatient Medical Care at Indian Health Services Facilities (2/16/78)

FSIIS–78–55 — Revisions to State Assessment Guide (2/16/78)

FSIIS–78–56 — Medicaid Quality Control: State Medicaid Quality Control Workshops (2/21/78)

FSIIS–78–57 — Utilization Control Validation Survey for the Quarter Ending 12/31/77 (2/21/78)

FSIIS–78–58 — Amendments to HMO Contract Regulations (42 CFR 449.82) (2/21/78)

FSIIS–78–59 — Revocation of Supplement D, Handbook of Public Assistance Administration (2/21/78)

FSIIS–78–60 — Supplement to Preamble of Regulations on Long-term Care Facility Reimbursement (42 CFR 450.30(a)(3)) (2/21/78)

FSIIS–78–61 — Medicaid QC Positions (2/23/78)

FSIIS–78–62 — Training Session on (1) the EPSDT Model Management Information System, and (2) EPSDT Program Data Requirements (3/3/78)

FSIIS–78–63 — Suspension of EPSDT Penalty Reviews Under Present Regulations (3/9/78)

FSIIS–78–64 — State legislative Assignments on Committees with Jurisdiction Over Medicaid (3/10/78)

FSIIS–78–65 — Developmental Review in the EPSDT Program (3/10/78)

FSIIS–78–66 — IMM Seminar on Medicaid Eligibility Management (3/13/78)

FSIIS–78–67 — Follow-up Central/Regional Office Systems Staff Meeting (3/13/78)

FSIIS–78–68 — Physical Relocation of Office of the Director (3/15/78)

FSIIS–78–69 — Bill Processing System Test (3/15/78)

FSIIS–78–70 — Psychiatric Programs Accredited by Joint Commission for the Accreditation of Hospitals (JCAH): State Plan Preprint Language (3/17/78)

FSIIS–78–71 — Restructure of Medicaid Regulations (3/23/78)

FSIIS–78–72 — Notification to State Medical Agencies of Relief from Financial Liability under section 1903(g)(1) for LTC facilities (3/28/78)

FSIIS–78–73 — Processing of HEW Audit Agency Reports (3/28/78)

FSIIS–78–74 — State Assessment Conference (3/29/78)

FSIIS–78–75 — Audit Follow-up Systems (3/29/78)

FSIIS–78–76 — Medicaid Budget Workshop for Regional Budget Staff (3/30/78)

FSIIS–78–77 — Establishing quantitative Objectives for EPSDT—DHEW Recommended Target Health Assessments by State for FY 1978 (3/30/78)

FSIIS–78–78 — Tentative Schedule of Activities and Information Requested from Regions for the Utilization Control Validation Survey, (3/31/78)

FSIIS–78–79 — Regional Office Staff Role in the Institute for Medicaid Training Sessions (3/31/78)

FSIIS–78–80 — Work Plans—Action by April 19, 1978 (4/3/78)

FSIIS–78–81 — Medicaid QC (4/4/78)

FSIIS–78–82 — Institute for Medicaid Management Regional Coordinators' (4/4/78)

FSIIS–78–83 — 1. Designation of Full Time Eligibility Specialists
2. Central Office Eligibility Workshop (4/5/78)

FSIIS–78–84 — Financial Management Resources (4/7/78)

FSIIS–78–85 — Implementing the EPSDT Immunization Initiative (4/11/78)

FSIIS–78–86 — Medicaid Eligibility—Update on Implementation of Section 11 of P.L. 95–142 (4/13/78)

FSIIS–78–87 — HMO's and Medicaid Approaches to Capitation Contracting (4/13/78)

FSIIS–78–88 — Proposed Medicaid Quality Control (MQC) Review Process (4/14/78)

FSIIS–78–89 — Proposed regulation on Rural Health Clinic Services (4/14/78)

FSIIS–78–90 — Medicaid Final Regulation on Prohibition Against Reassignment of Provider Claims (4/14/78)

FSIIS–78–91 — Medicaid Final Regulation on Reasonable Cost Reimbursement of Inpatient Hospital Service (4/14/78)

FSIIS–78–92 — Third and Fourth Quarter Work Plans (also see FSIIS 78–80) (4/14/78)

FSIIS–78–93 — Final Regulation on Medicaid Quality Control Systems; Expansion of Information requirements (4/18/78)

FSIIS–78–94 — Requirements for EPSDT for FY 78–19 Program Improvement Plans (PIP) (4/18/78)

FSIIS–78–95 — Request for Abortion Data from the United States District Court, Eastern New York (4/20/78)

FSIIS–78–96 — State Assessment Conference (4/24/78)

FSIIS–78–97 — State Sampling Plans for Medicaid Quality Control (5/3/78)

FSIIS–78–98 — Utilization Control Instructions for Reviewing States' Showing Under Section 1903(g) for Quarter Ending 3/31/78 (5/4/78)

FSIIS–78–99 — Regional Liaison Assignments (5/4/78)

FSIIS–78–100 — Transfer of Utilization Review (UR) Waiver Authority—Section 1903(i)(4) (5/4/78)

FSIIS–78–101 — Central/Regional Office Information Systems Staff Meeting (5/12/78)

FSIIS–78–102 — Delegations of Authority for the Medicaid Program, title XIX of the Social Security Act (5/12/78)

FSIIS–78–102A — Delegations of Authority for the Medicaid Program, Title XIX of the Social Security Act, dated May 8, 1978 (6/9/78)

FSIIS–78–103 — Request for Cost Estimates for State MR/IPR Teams (5/17/78)

FSIIS–78–104 — Weekly Activities Reports (5/23/78)

FSIIS–78–105 — State Plan Amendment Approval Time Status Report February 1978 (5/23/78)

FSIIS–78–106 — Visits to the Governors by the PROs (5/23/78)

FSIIS–78–107 — Training for Regional Staff in the Use and Training of Orientation to Medicaid—The Federal Perspective (5/24/78)

FSIIS–78–108 — Training Session on Rural Health Clinic Regulations (5/24/78)

FSIIS–78–109 — Statistical Report on PSRO Implementation (5/24/78)

FSIIS–78–110 — Medicaid Quality Control Negative Case Action Implementation Plans for the April–September 1978 Reporting Period (5/24/78)

FSIIS–78–111 — Request for Storage Cost Information (5/26/78)

FSIIS–78–112 — Redelegation of Responsibility for PCO–11 Form, Transmittal and Notice of Approval of State Plan Material (5/27/78)

FSIIS–78–113 — Quarterly Medicaid Eligibility Workshop (July, 1978) (5/26/78)

FSIIS–78–114 — State Plan Amendment Approval Time Status Report—March 1978 (5/26/78)

FSIIS–78–115 — Request for Abortion Data (6/1/78)

FSIIS–78–116 — Sending Explanation of Benefit (EOB) Notices in States with Approved Medicaid Management Information Systems (MMIS) (6/7/78)

FSIIS–78–117 — First Set of Recodified Regulations (6/9/78)

FSIIS–78–118 — Proposed Project Study of the Characteristics of Medicaid Ineligibles (6/9/78)

FSIIS–78–119 — Proposed Medicaid Quality Control (MQC) Review Process (6/9/78)

FSIIS–78–120 — Medicaid Quality Control (6/17/78)

FSIIS–78–121 — Tentative Schedule of Activities for the Utilization Control Validation Survey for the Quarter Ending 6/30/78 (6/14/78)

FSIIS–78–122 — Request for Review and Comment on *Orientation to Medicaid The Federal Perspective* (6/15/78)

FSIIS–78–123 — Responsibility for Reviewing Quarterly Showings and Conducting Validation Surveys in Utilization Control and Conducting EPSDT Penalty Surveys Assigned to the Division of Management (6/15/78)

FSIIS–78–124 — State Assessments Workshop (6/20/78)

FSIIS–78–125 — Study of Level of Care (Skilled Care Definitions) (6/20/78)

FSIIS–78–126 — Quarterly Medicaid Eligibility Workshop (July, 1978) (6/21/78)

FSIIS–78–127 — Utilization Control Validation Survey for the Quarter Ending 3/31/78 (6/22/78)

FSIIS–78–128 — FINAL REPORT—Evaluation of Medicaid Administrative Costs, March 20, 1978 (6/22/78)

FSIIS–78–129 — Statistical Report on PSRO Implementation (6/27/78)

FSIIS–78–130 — State Plan Preprint Status Report (6/28/78)

FSIIS–78–131 — Criteria for EPSDT Program Improvement Plans for Fiscal year 1979 (6/30/78)

FSIIS–78–132 — Medicaid Eligibility and Medicaid Third Party Liability—2nd Update on Implementation of Section 11 of P.L. 95–142 (7/10/78)

FSIIS–78–133 — HCFA Work Planning (7/11/78)

FSIIS–78–134 — Medicaid Quality Control (7/12/78)

FSIIS–78–135 — Medicaid Initiative (7/12/78)

FSIIS–78–136 — Eleventh Annual Conference of State Medicaid Directors (7/12/78)

FSIIS–78–137 — Disallowance Based on Lack of Provider Agreements with SNFs and ICFs (7/13/78)

FSIIS–78–138 — Preliminary Report on Meeting Held June 9, 1978, with the National Association of Chain Drug Stores, Inc., and the National Association of Retail Druggests (7/14/78)

FSIIS–78–139 — Instructions Concerning Medicaid Bill Processing Systems Prepayment Verification of Independent Laboratory Certification Requirements and Authorized Service Performance (7/17/78)

FSIIS–78–140 — Regional Analysis of OA–25 Estimates—DUE August 29, 1978 (7/18/78)

FSIIS–78–141 — Regional Reporting Format for EPSDT Activities (7/18/78)

FSIIS–78–142 — Utilization Control: Instructions for Reviewing States' Showings under Section 1903(g) for the Quarter Ending 6/30/78 (7/20/78)

FSIIS–78–143 — Public Disclosure of Program Compliance Information (7/21/78)

FSIIS–78–144 — Availability of Technical Assistance Relative to Section 104 (Handicapped) Regulations (7/24/78)

FSIIS–78–145 — Utilization Control Validation Survey for the Quarter Ending 6/30/78 (7/24/78)

FSIIS–78–146 — Reimbursement for Rural Health Clinic Services (7/25/78)

FSIIS–78–147 — Request for State Assessment Information (7/25/78)

FSIIS–78–148 — Supplement to State Assessment Guide Re: Abortions, Sterilizations, and Family Planning (7/27/78)

FSIIS–78–149 — Updating Chart "Medicaid Services State by State" (7/31/78)

FSIIS–78–150 — Central/Regional Office Systems Staff Meeting (7/31/78)

FSIIS–78–151 — States Initiatives Toward the Control of Medical Assistance Costs (8/3/78)

FSIIS–78–152 — Proposed HCFA Regulation requiring 60 Day Public Notice of Change in Reimbursement Level—No Effect on Drug Cost Levels (8/3/78)

FSIIS–78–153 — Request for Information on Selected Changes in State Medicaid Programs for the Period January 1 through June 30, 1978 (8/7/78)

FSIIS–78–154 — Statistical Report on PSRO Implementation (8/8/78)

FSIIS–78–155 — Regional Liaison Staff Assignment (8/8/78)

FSIIS–78–156 — State Plan Amendment Approval Time Status Report—April 1978 (8/8/78)

FSIIS–78–157 — State Assessment Guide (8/15/78)

FSIIS–78–158 — Reasonable Cost-Related Reimbursement for Long-Term Care Facility Services (8/15/78)

FSIIS–78–159 — Revision of State Plan Preprint (8/18/78)

FSIIS–78–160 — Institute for Medicaid Management Visit to Regional Offices (8/18/78)

FSIIS–78–161 — Request for Information in Subpart of the Medicare/Medicaid Program Integration Projects (8/18/78)

FSIIS–78–162 — State Assessment Workshop (8/21/78)

FSIIS–78–163 — Abortions, State Plan Amendments (8/21/78)

FSIIS–78–164 — FY 1979 Resource Management Planning Meeting (8/21/78)

FSIIS–78–165 — Medicaid Orientation Training Workshops for Trainers (8/22/78)

FSIIS–78–166 — Statistical Report on PSRO Implementation (9/1/78)

FSIIS–78–167 — Medicaid Resource Management System (9/6/78)

FSIIS–78–168 — Task Force on Medicaid Bureau Financial Management Activities (9/6/78)

FSIIS–78–169 — Medicaid QC (MQC) Coordination Meetings (9/11/78)

FSIIS–78–170 — Directory of Regional HMO Contracts, (9/14/78)

FSIIS–78–171 — Regional Office Role in Abortion Monitoring (9/15/78)

FSIIS–78–172 — Regional Analysis of OA–25 Estimates—DUE November 10, 1978 (9/18/78)

FSIIS–78–173 — Tentative Schedule of Activities and Information Requested from ROs for UC Validation Survey for the Quarter Ending 9/30/78 (9/19/78)

FSIIS–78–174 — MQC Training Workshop for Statisticians, (9/19/78)

FSIIS–78–175 — Rural Health Clinic Regulations (9/19/78)

FSIIS–78–176 — Conference Call Schedule: October, November, December 1978 (9/19/78)

FSIIS–78–177 — Provider Reimbursement Settlement Information (9/21/78)

FSIIS–78–178 — State Plan Amendment Approval Time Status Report (9/30/78)

FSIIS–79–1 — State Assessment Scheduling and Reports, (10/10/78)

FSIIS–79–2 — Report on Selected Changes in State Medicaid Programs (10/11/78)

FSIIS–79–3 — Approval of State's Cost-Related Reimbursement Plans (10/11/78)

FSIIS–79–4 — State Plan Amendments on Rural Health Clinic Service (10/17/78)

FSIIS–79–5 — Instructions Concerning the Monitoring of State Progress on Approved Advanced Planning Documents for Information Systems (10/19/78)

FSIIS–79–6 — Medicaid Quality Control Training Workshop for Statisticians (10/23/78)

FSIIS–79–7 — Medicaid Quality Control Review Process, (10/23/78)

FSIIS–79–8 — Status of Medicaid Minimum Data Set and Information on New Technical Assistance Contract (10/24/78)

FSIIS–79–9 — Medicaid Quality Control Survey Planning July 1978—March 1979: Expiration 1/31/80 (10/24/78)

FSIIS–79–10 — UC: Instructions for Reviewing States' Quarterly Showings Under Section 1903(g) for the Quarter Ending 9/30/78 (10/26/78)

FSIIS–79–11 — Identification of FFL and Non-FFL Cases, (10/30/78)

FSIIS–79–12 — State Systems Requests for Automatic Data Processing Systems, Equipment, and Services (10/31/78)

FSIIS–79–13 — Legislative Proposals Submitted by the Medicaid Bureau for the FY 1981 Budget/ Legislative Cycle (10/31/78)

FSIIS–79–14 — State Plan Amendment Approval Time Status Report—June 1978 (10/31/78)

FSIIS–79–15 — State Plan Amendment Approval Time Status Report (11/3/78)

FSIIS–79–16 — Subsampling and Reporting Periods for July 1978 through March 1979 (11/3/78)

FSIIS–79–17 — Implementing the EPSDT-Public Housing Collaborative Effort (11/6/78)

FSIIS–79–18 — Attached Report by GAO HRD–78–151, Dated September 26, 1978 (11/13/78)

FSIIS–79–19 — Measurement of MQC Savings (11/15/78)

FSIIS–79–20 — Publication and Distribution of State Management Review Reports (11/15/78)

FSIIS–79–21 — Follow-up CO/RO Systems Staff Meeting, (11/15/78)

FSIIS–79–22 — Need for Medicaid Bureau to Review States' Drug Monitoring and Utilization Systems, (11/20/78)

FSIIS–79–23 — Training Sessions on Sterilization Regulations (11/22/78)

FSIIS–79–24 — State Contracts-Policy Meeting (11/22/78)

FSIIS–79–25 — Medicaid Quality Control Negative Case Action Implementation Plans for October 1978 through March 1979 Reporting Period, (11/22/78)

FSIIS–79–26 — State Plan Preprint Status Report (11/24/78)

FSIIS–79–27 — State Telecopy Systems Accessible to the Medicaid Bureau (11/30/78)

FSIIS–79–28 — Utilization Control Validation Survey for the Quarter Ending 9/30/78 (11/30/78)

FSIIS–79–29 — State Plan Amendment Aproval Time Status Report—August 1978 (11/30/78)

FSIIS–79–30 — State Plan Amendment Approval Time Status Report (11/30/78)

FSIIS–79–31 — Cost Savings Estimate for FY 1981 Legislative Proposal on Eliminating Medicaid Coverage of Certain "Grandfathered" Groups (11/30/78)

FSIIS–79–32 — Format for Medicaid State Assessment Report Covers (11/30/78)

HEALTH STANDARDS AND QUALITY BUREAU

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS TRANSMITTALS

The Professional Standards Review Organizations (PSRO) transmittals contain administrative, procedural, and policy instructions for use in administering the PSRO program. A numeric listing of the PSRO transmittals issued through November 30, 1978 follows:

PSRO Transmittal No. 60 — Revision of "Grace Period" Requirements Under PSRO (1/17/78)

PSRO Transmittal No. 61 — PSRO Profile Analysis (1/23/78)

PSRO Transmittal No. 62 — Guidelines for PSRO Long-Term Care Review (2/28/78)

PSRO Transmittal No. 63 — PSRO Assumption of Review Responsibility in Long-Term Care Facilities (3/8/78)

PSRO Transmittal No. 64 — Reimbursement to PSRO Delegated Hospitals Not Participants in the Medicare Program (3/2/78)

PSRO Transmittal No. 65 — Modification of Concurrent Review Activities (3/17/78)

PSRO Transmittal No. 66 — Guide for Audits of Professional Standards Review Organizations (3/21/78)

PSRO Transmittal No. 67 — Disclosure of PSRO Data and Information to State Medicaid Agencies (3/21/78)

PSRO Transmittal No. 68 — Reimbursable Level of Effort for PSRO Personnel (3/28/78)

PSRO Transmittal No. 69 — Addendum to Transmittal No. 58— "Civil Rights Responsibilities of PSRO's" (4/20/78)

PSRO Transmittal No. 70 — Implementation of the Requirements of OMB Circular A-95 As PSROs Are Changed Over to the Grants System (4/24/78)

PSRO Transmittal No. 71 — Policies Applicable to the Submission of Sanction Reports in Accordance with Section 1157 of the Social Security Act (4/24/78)

PSRO Transmittal No. 72 — Medicare Trust Fund Reimbursement of PSRO Long-Term Care Review in Delegated Hospitals (5/25/78)

PSRO Transmittal No. 73 — PSRO Review in Specialty Hospitals (5/18/78)

PSRO Transmittal No. 74 — Reimbursement for Delegated PSRO Review (6/8/78)

PSRO Transmittal No. 75 — Guidelines for Sharing Information with Health Systems Agencies (HSAs) and other Uniform Hospital Discharge Data Set (UHDSS) Users (6/8/78)

PSRO Transmittal No. 76 — Modification of PHDDS Tape Acceptability Criteria; Proposed Revised PSRO Hospital Discharge Data Set (PHDDS) (6/15/78)

PSRO Transmittal No. 77 — Documentation of PSRO Review Determinations of Medicare Bills (6/15/78)

PSRO Transmittal No. 78 — Term of PSRO Automated Data Processing (ADP) Subcontracts (7/26/78)

PSRO Transmittal No. 79 — PSRO/Medicaid State Agency Relations; Implementation of Section 5(d) of P.L. 95-142 (8/2/78)

PSRO Transmittal No. 80 — Request for Information to be Used for Unit Cost Analysis (9/20/78)

PSRO Transmittal No. 81 — Implementation of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and Uniform Hospital Discharge Data Set (UHDDS) Classes of Procedures, ICD-9-CM for PSRO Reporting Purposes (10/20/78)

PSRO Transmittal No. 82 — PSRO Review of the Blue Shield Medical Necessity Project Procedures List (10/23/78)

PSRO Transmittal No. 83 — Information to Assist in Objective Setting (10/19/78)

Part VI, OBSOLETE SOCIAL SECURITY RULINGS

The following previously published Social Security Rulings are no longer applicable for Health Care Financing Administration purposes and will not be issued as HCFA Rulings:

1. Social Security Ruling 67-15
2. Social Security Ruling 68-39
3. Social Security Ruling 69-10
4. Social Security Ruling 69-51a
5. Social Security Ruling 69-64
6. Social Security Ruling 70-6
7. Social Security Ruling 70-16a
8. Social Security Ruling 70-25
9. Social Security Ruling 70-60
10. Social Security Ruling 71-18
11. Social Security Ruling 71-26
12. Social Security Ruling 71-46
13. Social Security Ruling 72-17
14. Social Security Ruling 73-8c

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